PEDIATRIC ASSOCIATES OF KINGSTON, LLC
FINANCIAL POLICY

Thank you for choosing Pediatric Associates of Kingston as your pediatrics provider. We are committed to providing the best care possible. Understanding your financial responsibility is considered part of your medical management. Our financial policy is an agreement between the providers of the practice and the child's parent, guardian, or responsible party(18+ yrs old). Your understanding of the financial policy agreement is important to our professional relationship.

INSURANCE
Payment for services is due at the time services are rendered except as outlined as follows. Insurance plans vary considerably, as we can not predict or guarantee what part of our services will or will not be covered. It is the responsibility of the patient to provide **accurate** and **timely** insurance information. Inaccurate or untimely information given to the staff that results in denial or non coverage by your insurance company results in the guarantor being responsible for payment.

NONEMERGENCY APPOINTMENTS
Preventive well visits, ADD/ADHD visits, and the like may be rescheduled if there are outstanding balances or if a co-payment is not paid at time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer, and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy (eg, vaccine and doctor visit coverage and referral/ authorization requirements for specialty care.)

BILLING
We accept cash, checks, MasterCard, Visa, or Discover. Outstanding balances are due within 30 days, unless prior arrangements have been made with our billing department. A **$5 billing fee** will be charged if your co-payment is not paid at time of service. A **$5 billing fee** will be added to balances more than 60 days past due. A **$5 billing fee** will be added to balances that remain outstanding more than 90 days and a final request for payment letter will be issued. Balances not paid in full within 10 days of the date on the final request letter **will** be forwarded to a collection agency. If your account is forwarded to a collection agency, we will continue to see your child on an emergency basis only for 30 days giving you time to find a new source of medical care.
_____**Initial**

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY
We are not able to bill your insurance and we can not accept assignment from them for the services performed. We will provide you with an itemized bill so that you may submit the charges to your insurance company for reimbursement. Not all services provided by this office are covered benefits in all contracts. Payment for services is due at the time of service. A **$5 billing fee** will be added to balances not paid at the time of service.
_____**Initial**

MISSED APPOINTMENTS/LATE CANCELLATIONS
Broken appointments represents a cost to us, to you, and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for canceled or missed appointments. For cancellations, 24 hours notice prior to the appointment is requested. A **$25 fee** will be charged for a **2nd** missed appointment. After a **3rd** missed appointment in a family within a 3 year period we will provide the family **30 days emergency care** as we have the right to discharge the family due to a failed professional relationship.
_____**Initial**

DIVORCED /SEPARATED PARENTS A divorced decree is a legal agreement binding only upon the two parties who made the agreement. Therefore, Pediatric Associates is not a part of the contract. The accompanying parent or adult is responsible for **FULL** payment at time of service. In case of a divorce, please do not put our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non custodial parent. We realize that temporary financial problems may affect timely payment of your account. We encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account. **____Initial**

IF WE PARTICIPATE WITH YOUR INSURANCE
All services performed in our office will be submitted as a courtesy to your insurance. All co-payments are due at time of service. Deductibles and coinsurance are your responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse us. However, the doctor's fee may be higher than what the insurance company reimburses or it may not be a covered service. Therefore, any balances not covered by insurance becomes the responsibility of the patient. In house lab test, developmental screenings , procedures such as wart treatment, after hours telephone care, etc is a example of a service that could be applied to deductible or a coinsurance. Our office is **not** responsible to know your insurance and what will or will not be covered. **_____Initial**

FORMS AND FEES
There is a **$10 fee** for the review and completion of school/child care forms not provided at the time of a well child examination. There is a **$10 fee** for completion of Family Medical Leave form. Family is required to fill out as much information as possible (reason, duration) A **$20 fee** is required for the transfer of **PEDIATRIC ASSOCIATES OF KINGSTON** records of the care provided for your children. Copies of immunizations and all visit including well visits and growth charts are included. A **$5 fee** is for Patient History, which is a **report** that includes dates of visits/diagnosis and immunizations received in our office. **_____Initial**

RETURN CHECKS
A **$25 fee** will be charged for all return checks and your account will be placed on a "**cash-only basis**" We will only accept payments by cash or credit card until the balance is cleared. **_____Initial**

THE FINANCIAL AGREEMENT
We must emphasize that as pediatric providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients , all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know your benefits your insurance company plan provides for you.

_____ _____
Child's Name Date of Birth Child's Name Date of Birth

_____ _____
Child's Name Date of Birth Child's Name Date of Birth

_____ _____ _____
Signature Relationship Date

Please circle Would you like a copy of Financial Policy ? ____Yes ____No