

Premier Pediatrics, Inc. – Office Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Please initial on each line and sign at the bottom recognizing that you have read and agree to each line item

- _____ On arrival, please check in at the front desk and present your current insurance card at every visit. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT.**
- _____ While the filing of insurance claims is a courtesy that we extend to our patients; **all charges not covered by your insurance company are your responsibility.**
- _____ According to your insurance plan, you are responsible for any and all co-payments, deductibles, coinsurances and any charges not covered by your plan.
- _____ It is your responsibility to understand your benefit plan and to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
- _____ If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit.
- _____ If you have no insurance, payment for an office visit is to be paid at the time of the visit. There is also a \$21 charge per vaccine if you are uninsured.
- _____ Co-payments are due at time of service. A **\$5 service fee** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the business day.
- _____ Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. All **balances are due upon receipt** of your bill.
- _____ If previous arrangements have not been made with our billing office; any account balance outstanding greater than 30 days will be charged a \$10 late fee. Any balance over 60 days will be forwarded to a collection agency. If forwarded to a collection agency you will be responsible for any and all collections fees assessed.
- _____ We require 24-hour notice for canceling any appointments. There is a **\$75** charge for any appointment if it is not canceled OR if 24-hour notice is not given. You are responsible for this charge regardless of insurance.
- _____ A **\$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- _____ To copy or transfer medical records we charge **\$2.73 per page for the first 10 pages; \$.57 per page for pages 11-50; \$0.23 per page for pages 51 and higher.** Ohio Law states that Premier Pediatrics has 30 days after the receipt of your request to provide you with your medical record.
- _____ If your child has school, camp, or sport forms to be completed, there is no charge for the first form. We have a 3 to 5 day turnaround time for all forms. If a form is needed sooner than 3 days, there is an additional **\$10** rush fee.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) _____

Responsible party member's name

Relationship

Responsible party member's signature

Date

PATIENT COPY

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