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.

- On arrival, please check in with our staff at the front desk. If you have any changes in your demographic information including e-mail address, phone number or address please notify the staff. If there is a change in your insurance, please notify us at this time. Your insurance will be verified. IF THE INSURANCE COMPANY YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR THE VISIT.

- If you need to designate a primary care physician with your insurance plan, make sure it is done prior to your visit. If your insurance company has not been informed that we are your primary care physicians as of the date of your visit, you will be financially responsible for the visit.

- According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

- Before making a well child exam appointment, check with your insurance company as to whether the visit will be covered as a healthy visit. Not all plans cover annual physicals, some limit you as to how many well visits you can have per year, some limit you as to when you can schedule them (has to be after birthday or > 365 days since the last one). Not all plans cover hearing, vision, and developmental screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of the visit.

- IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR BENEFIT PLAN. IT IS YOUR RESPONSIBILITY 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.

- Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan, and to provide us with their ID number, date of scheduled visit, and procedure codes if necessary.

- If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid at the time of your visit.

- Not all services provided by our office are covered by every plan. Any service deemed to not be covered by your plan will be your responsibility.

- If you have no insurance, payment for an office visit is to be paid at the time of the visit.

- Co-payments are due at the time of service. We reserve the right to add a $20 billing surcharge to all co-payments not paid at the time of the visit.

- We require 24 hour notice for canceling any appointments. There is a $50 charge for weekday appointments and $50 charge for Saturday appointments if they are not canceled and you do not show up for the visit, OR if 24 hour notice is not given. As a COURTESY we try to confirm appointments a day or two prior to the visit, BUT IT IS YOUR RESPONSIBILITY TO KNOW THE DAY AND TIME OF YOUR APPOINTMENT.
- A $20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
- If your child has school, camp, or sport forms to be completed, there is no charge for these services. We have a 3- to 5-day turnaround time for the forms. If a form is needed sooner than 3 days, there is a $20 RUSH FEE.
- In an effort to keep down office wait times, if you arrive more than 15 minutes late for your visit, we reserve the right to reschedule the patient's visit.
- When the office is closed, all calls get forwarded to the Doctor's cell phone. There is NO SERVICE and there is NO ABILITY TO LEAVE A MESSAGE. For all non-emergent phone calls such as making an appointment, confirming appointments, forms that need to be filled out, referrals, etc PLEASE CALL MONDAY-SATURDAY after 9am and NOT ON SUNDAYS SINCE THE OFFICE IS CLOSED ON SUNDAYS.

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: _____