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**MEADOWBROOK PEDIATRICS, P.C.**

**FINANCIAL PAYMENT POLICY**

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**The purpose of this form is to notify you of our office policy in advance.  Please read this carefully and if you have any questions, do not hesitate to ask a member of our staff.**

- Our office participates with many insurance companies.  Should your insurance coverage be with one of these companies, we will bill your insurance company along the guidelines of our contract.  Co-payments, co-insurance, deductibles and non-covered services that have not been satisfied, are the responsibility of the patient.  **If your insurance requires you to pay a copayment, it will be due at the time services are rendered.  A $15.00 service fee will be charged in addition to your co-payment if not paid at the time of service or within 5 days.**

- All visits; well, sick, telehealth, and phone consults are billed to your insurance company. You will be responsible for any copayment or deductible as required by your insurance.

- While most well visits do not have a copayment, if an illness or abnormality is discovered or a preexisting problem is addressed and that illness, problem or abnormality is significant enough to require extra work such as requiring bloodwork, x-rays, medications, or further counseling, a sick visit code will also be documented along with the preventative visit code.  This will be reported to your insurance company and a copay and/or deductible may be required.

- If you have insurance with which we do not participate, payment is expected at the time services are rendered.  We will provide you with an itemized receipt to submit to your insurance.

- If we are your primary care physician, make sure our name and/or phone number appears on your card.  If your insurance company has not been informed that we are your primary care physicians, you may be financially responsible for the visit.

- Before making an annual physical appointment, check with your insurance company.  Not all plans cover annual heathy physicals or hearing and vision 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 visit**.  Not all services provided by our office are covered by every plan.  Any service determined "not covered" by your plan will be your responsibility.**

- Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits.  Your remittance is due *within 30* business days upon receipt of your bill.  A **$15.00** re-bill fee will be assessed monthly on any outstanding balance greater than 30 days if previous arrangements have not been made.  *Unpaid balances may result in the postponement of scheduled well visits.*  Any balance over 90 days will be forwarded to our collection agency.

- If you schedule an appointment for a routine or sick visit and do not cancel 24 hours prior to the appointment, there will be a **$30.00 No Show fee** added to your account.

- A **$30.00** fee will be charged for checks returned for insufficient funds.  If a check is returned, all future payments must be cash or credit.

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04/30/2020
Revised 5/26/2021

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- We charge **$15.00** to transfer medical records to another physician. Our office policy is that you pick these records up and take them to your new physician. You also have the option to download your child's chart directly from our patient portal at no cost.

- A $5.00 fee will be assessed for school/camp forms. A $10.00 fee will be assessed for more complicated forms such as FMLA forms, disability and letters of medical necessity. Payment must be received prior to forms being returned. We have a 2 to 3 day turnaround time for forms.

- If you choose to use your credit card for payment in our office there is a **$2.00** fee.

I authorize treatment by the providers of Meadowbrook Pediatrics, P.C. and assign insurance benefits for all services rendered.

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 in this policy.

Name of Patient(s):      _____        DOB:    _____

_____                _____

_____                _____

_____                _____

_____

Parent/Guardian name (Please print)

_____                _____

Parent/Guardian Signature                                              Date