OFFICE FINANCIAL POLICY 2014

Patient Name:_____ **Date of Birth:**_____

Westchase Pediatric Care is pleased to welcome you to our practice. Our goal is to provide your child with competent and compassionate health care. In order to serve you better, we want you to understand our financial policy.

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. We will bill most insurance companies for you if proper paperwork is provided to us. Co-payments are due in full at the time of service. If you have an annual deductible on your insurance that has not been met or you are responsible for co-insurance, we will need to collect the required amount on the day of service. When we receive an "explanation of benefits" from your insurance company, we will apply this amount towards your deductible/coinsurance. If the amount collected is less than what you owe we will send you a statement for the balance. If the amount you owe is less than the retainer collected, the excess amount collected will be credited to your account and can be refunded to you if you request it.

We accept cash and credit cards (MC/Visa/Discover/American Express). Checks are accepted from existing patients towards insurance co-pays and deductibles. Self pay patients are required to pay by cash/credit card.

Your agreement with your insurance carrier is a private one and we are not party to your contract. We do not routinely research why an insurance carrier has not paid or why it paid less than anticipated. If an insurance carrier has not paid within 60 days of billing, the amount due will be your responsibility, and will be payable in full by you. If your insurance carrier changes, you must notify us immediately. If insurance information is not provided within 30 days of office visit, you will be responsible for any visits during that time.

NON COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial. Periodic preventive health services may or may not be covered under your health insurance policy or may have annual limits. However they may be required by your physician.

STATEMENTS: If you have a balance due on your account, you will receive statements from the office. The letter you receive from your insurance carrier with explanation of benefits will show the amount that is your responsibility. This is considered as your first statement. If no payment is received within 30 days, an additional statement will be mailed. If no payment is received within 30 days, a final bill will be sent to the address on record. Postage and late charges will accrue for additional statements. If payment is not made within 2 weeks of this final notice and no payment arrangements have been made, then the account will be sent to collections. The office will charge a 30 % surcharge to amount due, if the account is sent to collections. The office will charge a fee of $ 30 for bounced/returned checks.

MINOR PATIENTS: The adult signing this policy is responsible for full payment. It is your responsibility to arrange transfer of amount due to the grandparent/guardian/friend who accompanies child to the office. In case of divorced/separated parents, legal payment arrangements must be worked out prior to appointment.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require 24 hours notice to cancel appointments. Your first missed appointment will receive a courtesy warning. You will be charged $ 35 for subsequent "no-shows". Patients who miss appointments repeatedly without notice may be dismissed.

I have read, understood and agree to the above financial policy for payment of dues.

Signature_____ Name_____Relationship_____Date_____