

FINANCIAL POLICY



Patient Name/DOB: _____

Thank you for choosing Carolina Pediatrics. We are committed to the successful treatment, health and well-being of your child, and strive to offer excellent care while maintain a patient friendly environment. At Carolina Pediatrics we recognize that health care is expensive and insurance requirements can often be confusing and frustrating. Even so, it is important that you have a clear understanding of our Financial Policy and be aware of payment expectations.

Your insurance is a contract between you, your insurance company, and/or your employer. Our office is not a party to that contract or possible restrictions they may apply to your care or payment. Our relationship is with you and your child, not the insurance company. We will file your insurance with your insurance carrier as a COURTESY; however payment is the ultimate and sole responsibility of the patient/parent/guardian.

INSURANCE

You will be required to complete new patient information forms, and update insurance information at least once each year. However, due to HIPAA, and other privacy laws we require that you bring and present a picture ID as well as your CURRENT insurance card at each visit. If you have a change in insurance carriers, drop coverage, receive new cares or in any way experience a change in coverage you must notify our office immediately. Failure to do so may result in insurance claim denials that could cause all charges to become your responsibility. It is important that you become familiar with the benefits, limitations and responsibilities determined by your insurance plan.

If we are unable very eligibility of your coverage, or you do not have your card, full payment will be due at the time of service.

REFERRALS AND AUTHORIZATIONS

If your insurance plan requires the designation of a PCP/PCM (Primary Care Physician or Primary Care Manager), it is your responsibility to make sure the insurance carrier is informed of your choice. If a provider with Carolina Pediatrics is not listed as your designated PCP, we may not be able to treat you or your child. We may require payment in full at the time of service until you notify your carrier of the correct PCP designation.

CO-PAYS, DEDUCTIBLES, CO-INSURANCE and ELIGIBILITY

While we participate with many health plans, and will file claims to those plans as a courtesy, you are responsible for any amounts pre-determined by the carrier to be patient responsibility. This may include a co-pay, deductible or co-insurance. It is our policy to collect these amounts up-front at the time of service. Failure to pay a co-pay at the time of service may be considered a violation of your contract with your insurance carrier. Please be prepared to make any payment deemed patient responsibility at the time of service. If Carolina Pediatrics does not participate with your health insurance plan, payment is due in FULL at the time of service. We will be happy to provide you with the necessary paperwork to file with your plan directly for any reimbursement you may be eligible to receive. We do not accept divorce decrees as assignments of responsibility for a child's co-pay, deductible or co-insurance. It is the responsibility of the parent accompanying the child at the visit to pay any amounts due and seek reimbursement for the other parent.

UNINSURED PATIENTS

Payment is due in full at the time of service. If an emergency prevents you from paying your entire balance at the time of service we require at least 50% of the total and you may speak with an Account Manager to set up payment arrangements on the balance.

PAST DUE BALANCES

Balances not paid within 30 days are considered past due. If your insurance company has not responded to our claim for payment in this time period, we will either ask for your assistance in contacting your insurance company or require payment from the patient/parent/guardian. Balances not paid in full within 90 days will result in your account being locked and potentially forwarded to a collection agency and any associated fess may be added to your account. If you move or relocate with an outstanding balance it is your responsibility to notify us of your new address. We cannot be responsible for undeliverable mail. Patients with locked accounts and/or past due balances will be required to make payment in full before future appointments can be scheduled. If full payment is not possible a minimum deposit toward the payment and a signed payment agreement will be required.

NO SHOWS

Appointments are made and reserved for patients in good faith. Failure to show up (with or without prior contact) for 3 scheduled appointments may result in dismissal from the practice.

I _____ acknowledge receipt and understanding of the items outlined in this Financial Policy.
(Print Name)

Patient/Parent/Guardian Signature

Date