

PEDIATRICS IN BREVARD FINANCIAL POLICY

It is the policy of this office to help keep health care costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Bring your child's current health insurance card to **every** office visit.
- Notify us of any changes in insurance, address, phone #, etc.
- Pay your co-pay or deductible at the time of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- Double check with your plan as to the participation status of Pediatrics in Brevard. Please understand you are responsible for verifying this information with your carrier.
- Verify coverage limitations prior to appointment date.

Monthly Statements: If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us, the balance on your account is due and payable within 14 days of the statement date. If you are unable to pay the amount due or if you disagree with the billed amount, contact our billing department immediately. There is a **\$10 statement fee for any balance over 30 days.** ()

Co-Payments: *We are required by our insurance contracts to collect all applicable co-pays at the time of service. If a co-pay is not paid at the time of service, a \$25 late fee will be assessed. This is in addition to a statement fee if applicable.* ()

Payment Options if you are Uninsured or Out of Network: Well child visits and vaccines must be paid in full at the time of service. For sick visits, a deposit will be collected up front. You must stop at check-out to pay the remainder of the charges, if applicable. If payment cannot be made in full at the time of service, a budget agreement can be made prior to the visit.

Insurance Release: This is to certify that I have been informed that my health plan may not be liable for service rendered if any of the following conditions apply:

- Provider not participating in my health plan.
- Unmet deductible under my health plan contract.
- Services not covered under my health plan contract.
- Well child check-ups, immunizations, vision and hearing screenings may not be covered by some insurance plans. Please check with your insurance carrier if you are uncertain about coverage for routine services. If immunizations are not covered by your insurance plan, please advise the nursing staff, **prior to receiving vaccines**, to receive lower cost state funded vaccines.

Returned Checks: There is a fee (currently \$30) for any checks returned by your bank.

Ledgers: There is a fee (currently \$10) if you are needing a print-out of your account, for payment history, etc. The fee is due prior to receiving the ledger.

After Hours Visits: Our Rockledge and Melbourne (Hibiscus Blvd) offices offer extended hours for *sick and emergent care*. Please be advised that there is an additional fee for these visits. Any office visit scheduled on Saturdays, Sundays, or any holiday is considered extended hours.

Automobile Accidents: If your child is involved in an automobile accident, he/she must first be evaluated at a hospital ER. If your child requires follow up care with his/her primary care doctor, we will provide this service, however, the visit is considered out of network as we do not have a contract with auto insurance companies. **These visits must be paid in full at the time of service.**

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Missed Appointments: If a patient repeatedly misses scheduled appointments, without notice, a fee of **\$50 will be charged.** () Patients who continue to miss further appointments may be asked to transfer their records to another provider outside of Pediatrics in Brevard.

Transfer of Records: You will need to complete the authorization to release records form, which can be obtained from our office. This form needs to be complete in its *entirety* in order for us to process the request. All balances should be paid in full before records are transferred.

Divorce: In case of divorce or separation, the parent or individual with whom the child resides, will be the parent responsible for all fees for services rendered, independent of insurance coverage and/or what a divorce decree may state. It is that parent's responsibility to collect from the other parent.

Newborns: Most insurance carriers require a newborn be added to the parent's policy within 30 days. You are fully responsible for any fees incurred if your newborn is not added within the allotted time. You may receive a statement within that time if we have not received verifiable insurance information. Please contact the billing department once you have received your newborn's active insurance information.

Secondary Insurance: Pediatrics in Brevard *does not* file secondary insurance, this includes Medicaid. You will be responsible for all co-pays, deductibles, coinsurances, etc., that apply to your primary insurance, at the time of service.

Past Due Accounts: If your account becomes past due, we will take the necessary steps to collect this debt. **If we refer your account to a collection agency, you agree to pay all of the collection costs which are incurred.** () If an account is referred to a collection agency, due to non-payment, the providers of Pediatrics in Brevard will no longer be able to provide medical care to your children. In this case, the guarantor

will be notified of this by certified mail and given adequate time to find a new medical provider. All accounts sent to the collection agency will be reported to the Credit Bureau.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

This is an agreement between Pediatrics in Brevard, as the creditor, and the Patient/Guardian/Parent as debtor/guarantor, named on this form. In this agreement, the words "you", "your", and "yours" mean the debtor/guarantor. The word "account" means the account that has been established to your name to which charges are made and payments credited. The words "we", "us", and "our" refer to PIB.

I have read this Financial Policy as outlined above and on the front side of this page, and understand that I am ultimately responsible for the charges incurred and any additional charges or fees if applicable.

Patient's name: _____

Patient's DOB: _____

Guarantor name: _____

Guarantor Signature: _____

Relationship to Patient: _____
(Parent, Grandparent, Self, Guardian, etc..)

Date of Signature: _____