

Patient Financial Responsibility Statement

Our primary goal as providers of healthcare services to your children is to deliver outstanding clinical care and service. We strive to serve our patients efficiently and effectively. You can help us achieve our goals of keeping our costs down and care our top priority, by being prepared to pay your copays at the time of service, and by paying off your balances within 30 days of being billed. Co-pays will be collected at the time of your appointment, and we will request payments on any previous balances at that time, as well. We accept cash, checks, debit cards, and credit cards.

The patient, parent, or guardian accompanying the patient is responsible for providing our office with a valid and current insurance card. We must be notified of any changes, prior to rendering services. Patients unable to provide valid insurance information, may be required to pay in-full at time of service or reschedule their appointment.

The patient, parent, or guardian accompanying the patient, must pay any co-payment and applicable deductible amounts, as directed by insurance, at the time of service unless prior arrangements have been made with our office.

The bill will be filed to the health plan on record for direct payment to our office. If your insurance has not paid our claim within 90 days, we will request payment from the patient.

The patient, parent, or guardian will be responsible for any services that are not covered, or are noted as patient responsibility by your health plan.

Reasons Health Plans May Refuse or Deny Payment of a Claim:

- The provider of service is not listed as the Primary Care Physician (PCP) for the patient, and/or the provider is out of network.
- Services provided were for a pre-existing illness that is not covered by the patient's health plan.
- The patient's deductible and/or co-insurance amount has not been met.
- The type of medical services received is not covered by your plan or, is subject to a maximum benefit allowance (generally per calendar year).
- The health plan was not in effect at the time services were rendered.
- The patient has other insurance that is the primary carrier, which must be filed first.
- The insurance company *requires the patient* to contact them to verify if the patient is covered by another health plan (generally required to update *at least annually*).
- Services indicate the patient was seen for an injury or accident. The patient must provide information regarding the accident or injury to the health plan as requested, before the claim will be processed.
- The patient or dependent receiving the services is not showing as a covered dependent under the health plan.

Please note that the payment collected at the time of service, may not reflect the full amount due by the patient, after the insurance company processes the claim. Our office is not responsible for any limitations in coverage that may be included in your plan.

Should your health plan deny claims for any of the above reasons, you will then be responsible for the bill. It is the responsibility of the patient to pay denied amounts in full, once you receive a statement from our office.

We advise our families to understand their insurance benefits, and to review their Explanation of Benefits (EOB) and patient billing statements carefully. We are happy to help you with any questions you may have regarding these reports. If you feel there has been an error, always contact the appropriate party with questions within a timely manner. Balances owed by the patient, are considered past due after 30 days of the initial billing statement, if there have been no payments made to your account.

Partial payments are always welcomed. As long as they are made monthly, your account will stay in "good standing". We understand that things come up and special circumstances sometimes arise. We are happy to work with you if you need additional time to pay a bill. It is important that you notify our billing office of your situation, so we are all aware and on the same page. We are here to assist and to listen. Just let us know.

Authorized Signature: _____ Date: _____