PEDIATRICS SOUTH
FINANCIAL POLICY
(18 YRS AND OLDER)

OFFICE USE ONLY

Patient Number: _____

Date of Birth: _____

Date Notice Received: _____

Patient Name:_____

Insurance and Payments

We are willing to bill all insurance companies, whether we participate or not. We must emphasize that as healthcare providers, our relationship is with **you** and **not your insurance company**.

- **You are responsible for supplying the office with accurate and current billing information including any demographic changes and a copy of your insurance card.**
- **It is your responsibility to know the specifics of your benefit plan.**
- **Any insurance co-payments or non-covered services are to be paid at the time of service.***
- **If your co-payment is not paid at the time of service, you will be charged a fee of $5.00 for billing.**
- **For your convenience, payments can be made with cash, checks, VISA, MasterCard, Discover or debit cards.**
- **Any balances owed are to be paid no later than thirty days after the bill is received. We will place a courtesy call beyond this point as a payment reminder.**

*(The only exception is if you are on Medical Assistance through the Pennsylvania Department of Welfare)

Self-Pay Accounts

Patients with no insurance coverage are expected to pay in full at the time of service. If you will not be able to pay in full, you must contact our billing department prior to seeing the doctor to make payment arrangements. To contact our Billing Department, please call 724-969-5076.

Child Custody/Divorced Parents

The adult accompanying the patient must pay at the time of service regardless of who the responsible party is. We will not become involved in mediating financial arrangements between parents. It is the parents' obligation to work out an agreement themselves or through the court system.

Fee Schedule for Services:

Forms and Baby Books

All school/daycare forms will be filled out during a patient's physical without incurring a fee. At any other time there is a $10.00 fee for filling out forms or re-creating baby books. Drivers permit forms and other same-day form service will be charged a $15.00 fee. Forms **will not** be completed unless physicals are up-to-date.

Returned Check Fee

Any cost charged to us by our bank will be passed on to the responsible party. For example, our bank charge for an NSF check is $36.00. This amount will be billed to the patient. All NSF checks are deposited a second time. If this check does not clear the bank the second time, a second $36.00 will appear on your balance.

No Show Appointments

When an appointment is scheduled with a doctor, time is specifically allocated for your child. When an appointment is not canceled in advance and the patient "no-shows", another patient that needed to be seen may have been unable to because the time slot was already taken. We request the courtesy of a phone call to cancel your appointment prior to your appointment time. If you fail to contact our office, you will be charged a no-show fee. As of May 1, 2010, the no-show fee is $50.00. Appointment reminder phone calls for physicals may be generated by our practice as a **courtesy**.

Evening/Saturday Hours: There is an additional $30.00 fee for **ill** visits after 5:00pm and Saturdays.

Personal Copies of Medical Records

If you wish to obtain **personal** copies of your medical records, you may submit a signed request. According to HIPAA, state, and federal regulations, it is ensured that copying medical records is an affordable process for patients while reimbursing medical practices for copying costs and postage. We will provide you with current fee schedule upon request. Please note we are always happy to provide you with a copy of vaccine record and last physical **free of charge**.

Late Arrival

As a courtesy, please be on time for your scheduled appointment. If you are more than 20 minutes late, it may be necessary to re-schedule your appointment to another day in order to prevent inconveniencing other patients.

I have read, understand and agree to the above Pediatrics South Financial Policy. I also understand and agree that such terms may be amended by the practice at any given time.

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Signature of Patient *(18 yrs and older)*