PEDIATRIC ASSOCIATES OF BROCKTON

Our Financial Policy/Insurance Waiver

THANK YOU for choosing Pediatric Associates of Brockton as the healthcare provider for your child(ren). Providing *quality medical care* for our patients is our primary concern. We must emphasize that as medical care providers, our relationship is with you, **not your insurance company**. We understand that you may be on a managed care plan and we will try to work with your plan, as we are able. We will try to refer you to a hospital or specialist with in your network, if an acceptable one is available; however, due to the volume of patients we have and all the different insurance coverage, it is impossible for us to keep track of what facilities/labs are accepted under your plan. Therefore, it is your responsibility to make sure your insurance is accepted at the facility/lab we refer you to. In order to achieve these goals and make our relationship with you a positive one, we need your assistance and understanding of our payment policy which is described below.

SELF PAY PATIENTS: Full payment is due at the time of service unless an alternate financial agreement has been made with our Billing Office. We Accept cash, personal checks, Visa, MasterCard, Discover and American Express. A fee will be charged for all insufficient checks.

CONTRACTED PPO/HMO IN NETWORK: Co-pays are due at the time of service. ID cards must be presented at each visit.

BILLING: We will bill your insurance company for all services provided in the office. You are responsible for any balance due. All statements will go out to the primary care givers address (where the patient resides). If you feel that another party other than your insurance company or yourself is responsible for the payment, it is *your responsibility to make payment* and collect from such party.

MEDICAID/MASSHEALTH: Current card *must be presented* prior to service or payment in full is expected.

ADVOCATE HEALTHCARE: We must have a copy of the patient's ID card in order for us to file insurance claims. If the patient is not on our eligibility list, you will be asked to sign a waiver accepting financial responsibility. No immunizations will be given if you cannot provide the child's ID card naming one of our doctors as the PCP unless you pay at the time of service.

ACCOUNT STATEMENTS: Every effort is made to avoid the cost of mailing statements; however, if a statement is sent it will indicate any amounts due by you. Your payment, in full, is due upon receipt of the statement, unless prior arrangements have been made with our billing department. If you feel your insurance made an error in paying the claim, <u>*contact them immediately*</u>. Parents(s) or legal guardian(s) of patients through the age of 26 years *are financially responsible* for any uncovered services provided by Pediatric Associates of Brockton.

PAST DUE ACCOUNTS: Seriously past due accounts will be referred to a collection agency. This will result in termination of services with our practice. We will gladly work with you to arrange a payment plan that you can handle. Please call our billing department to set up a payment plan.

Regardless of claims pending, timely payment for the total balance due is your responsibility. If your insurance company withholds payment for any reason, *you must* make payment and resolve the problem with your insurance company.

BANKRUPTCY: Any family filing bankruptcy must pay in full at the time of service. Any insurance payment will be refunded. Charts will be copied for transfer to another physician if you cannot comply with this policy.

IMPORTANT: We must have a copy of your current insurance card on file for all children. Your insurance company requires that the co-payment is provided at time of service. We are not allowed to bill for copays. Therefore, you *must* provide payment at time of service.

The person who brings the child in for treatment is responsible for payment of any copay or balance. *IF* there is a divorce situation, the parent who brings the child into the office is the person responsible for the charges. *We will not become involved with the particulars of your divorce.* We will provide a receipt so that the responsible party can reimburse them. We will not bill third parties for payment of balance due.

If you have any questions regarding your account at any time, please contact our Billing Department.

I have read and agree to the terms of this financial policy.

Patient Name's/DOB:

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Name:____ **Date:**______________________

Signature of Responsible Party