



The Pediatric Center – Financial Policies

We appreciate your selection of our practice for your children's medical care. To prevent any possible future misunderstanding, we have prepared the following summary of our financial policies.

We will require a copy of your insurance card and billing information. Please bring the card with you to each visit. If you join or change plans, please inform us immediately!! If you fail to inform us of any changes in coverage, you will be responsible for payment for services rendered. We will balance bill you per your insurance plan.

It is our policy that the person bringing the child to our office is responsible for payment at the time of the visit for services rendered, regardless of which parent has the ultimate legal obligation to pay for medical care. It is the parents' sole responsibility to settle these financial matters between themselves and caregivers.

FEES FOR SERVICE:

- * **BILLING FEE** - for co-payments not paid at the time of service - \$10 (in addition to the co-pay)
- * **MISSED APPOINTMENT FEE** - for physical appointments not cancelled 24 hrs. in advance = \$50. After 2 "No Shows" the fee increases to \$100 per visit. After 3 "No Shows" you may be asked to leave the practice.
- * **TELEPHONE CONSULTS** - After hours calls to our "Pediatric Triage" Center, between 9pm & 8am, will be directly billed to you, \$20/each.
- * **COPY OF MEDICAL RECORDS** - first copy is free, - if picked up at the office. Thereafter charges per CT law, currently at \$.65 per page plus postage for paper or electronic records if mailed. Records may be destroyed 7 years after last date of service per CT Law, so keep a copy.
- * **VFC/STATE VACCINES** - available for those who qualify, \$21/administration fee/dose.
- * **RETURNED CHECK FEE** - is \$35.

* NEW FORMS POLICY *

Effective 1/1/2014, there will be a \$10 fee per form per child. This includes school, camp, medication, allergy protocols, etc., whether sent in or brought in at the time of a visit. There will be a \$20 cap per child when more than 2 forms are given at the same time. Forms mailed in still require a one week turn-around time and an enclosed check, along with a self-addressed stamped envelope.

We will continue to offer our "Urgent Form" option for all forms that need to be completed within 48 hours or less for a \$20 fee per form with a \$40 cap per child.

No charges will be billed so payment must be made prior to forms being released.

Responsible Party's Statement, Authorization and Assignment of Benefits:

A photocopy of this authorization shall be considered as effective and valid as the original.

I authorize the release of any medical information necessary to process claims.

I authorize payment directly to The Pediatric Center for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse The Pediatric Center for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments, charges not covered under my insurance benefits and the above Fees For Service.**

Should your account become delinquent and turned over to our collection agency, appropriate fees will be added and we will start the process of dismissal from our practice. If your account goes to collections for a third time, you will automatically be dismissed from the practice. In the event that any legal action is brought to collect my account or any portion thereof, I agree to pay a reasonable sum for attorney's fees in addition to costs and disbursements as provided by statute.

I have read all the above and agree that, regardless of my insurance status, **I am ultimately responsible for the balance on my account for any services rendered.**

Childrens' Names: _____ Date: _____

Signature: _____ Relationship to Patient(s): _____

Home # _____ Mother Cell # _____ Father Cell # _____

Email: _____