

# South River Pediatrics

## Financial Policy

### **INSURANCE, DEDUCTIBLES, CO-INSURANCE & CO-PAYS**

South River Pediatrics currently participates with most insurance company. Please check with the staff to verify our participation in your insurance plan. The Primary Care Physician (PCP) must be selected on your child's insurance card as our practice: **South River Pediatrics** for benefits and coverage at time of visit.

The most recent insurance card must be presented at each visit to verify the information on file. Depending on your specific insurance plan, you may have a co-pay, co-insurance, and/or a deductible due at the time of your visit (some plans have a combination of two or three of the aforementioned items). Co-pay is a set dollar amount that you owe at the time of each visit. A co-insurance is an amount required by some insurance carriers that is above the deductible and co-pay amounts. A deductible is a set amount that is owed before the insurance begins paying toward the patient's services. ***Co-pays are due at the time of service.***

Any co-pays that are unpaid at the time of service due to the inability or refusal to pay for any reason are subject to an additional fee. As a courtesy, you have until 4:00pm on the same date of service to furnish payment or be charged an additional surcharge of \$10 per unpaid co-pay. Please ask our front desk for more details. Any balances that you may have incurred from prior or present dates of service will be collected when you visit the office. Our office bills the patient's insurance and makes every effort possible to ensure that claims are promptly and correctly processed.

### **NEWBORN ENROLLMENT**

After the birth of your new baby, be sure to fill out the necessary paperwork to add your baby to your insurance policy. Most insurance companies allow 30 days from the date of your child's birth to send in the paperwork. If you miss the deadline, claims filed on behalf of your newest family member may be denied and you may be financially responsible.

### **UNINSURED PATIENTS**

For any patients determined to have no medical insurance coverage, those patients are deemed to be self-pay patients.

Effective January 2015, all self-pay patients will be placed on a discounted sliding fee schedule. In order for the patient to receive the discounted rates, payment for services must be paid in full at time of service. If you have a question about the fee schedule, please feel free to contact our billing department.

### **AUTO ACCIDENTS/WORKERS' COMPENSATION**

Motor vehicle accidents (MVA) charges must be paid in full at the time of service. A receipt will be issued for you to submit to your auto insurance carrier. When and if we receive payment from your auto insurance we will provide you with a refund.

### **AFTER-HOUR CARE**

Please note that there is an additional charge for services provided outside of our regularly scheduled appointments. These include requests for visits after 5:00pm, emergency walk-in visits that disrupts the regularly scheduled business day, federal holidays, and Saturday office visits. This charge will be billed to your insurance company however this may become your responsibility if the insurance company does not cover this charge.

## ACCOUNT BALANCES

Any outstanding balance after 60 days may be referred to an outside collection agency. These accounts may be subject to a collection fee of 30%-40%, which will be added to the total balance due at the time of payment. Patients with continually delinquent accounts or those whose accounts have been sent to a collection agency are subject to discharge from South River Pediatrics.

Account balances may consist of any unpaid co-pays, deductibles, co-insurances or any balance that the insurance policy did not cover for a date of service. Balances are expected to be paid in full at the time of service. In the event that you cannot afford the entire balance, please contact our billing department.

## COLLECTION EFFORTS

We will make every effort to work with you to make payment arrangements should your bill become outstanding. As a courtesy to you, we will file claims with your insurance carrier. You are ultimately responsible for the charges from the services provided to the patient. You will receive a monthly statement reflecting balances still outstanding from your insurance carrier for which you are responsible. In the event that the account becomes outstanding, the payments must be regimented to clear the account within a 60-day period. *If you do not meet your financial obligation and refuse to pay the balance, we reserve the right to refuse care for and all subsequent visits.*

## METHODS OF PAYMENT

For your convenience, we accept cash, personal checks, money order, Visa, MasterCard, Discover, and American Express. There is a \$25 fee for all returned checks. If the office receives two returned checks, we will then only accept cash or credit as a form of payment.

## REFUNDS

In the case that there is a refund due to parent/policy holder, we ask that an e-mail request is sent to: [Jackie@southriverpediatrics.com](mailto:Jackie@southriverpediatrics.com). Please state (a) to whom the refund is to be made out to and (b) the address to which it will be mailed to. Refund will be mailed within seven (7) days of the request.

## LEGAL SERVICES

If any of our physicians and/or providers are asked to be involved in any legal matter requiring our participation pertaining to you or your child via telephone, court deposition, and/or court appearance we will charge you a fee for these services. This will include preparation time, professional time, and transportation costs. The fee for these services is three-hundred dollars (\$300) per hour will be billed to the parent whose attorney is requesting the information.

**I am aware that I am responsible for my bills in the event the insurance company denies any claims.** I have read and understand the office policies and procedures and agree to adhere to the specific guidelines outlined above. I am aware that I do not comply with above stated guidelines South River Pediatrics reserves the right to terminate care.

Parent/Legal Guardian Name: \_\_\_\_\_

Signature \_\_\_\_\_

Patient Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_