

## FINANCIAL PAYMENT POLICY

*The purpose of this form is to notify you of our office policy in advance. Please read this carefully and if you have any questions, do not hesitate to ask a member of our staff.*

Our office participates with many managed care insurance companies. Should your insurance coverage be with one of these companies, we will bill your insurance company along the guidelines of our contract. Co-payments, co-insurances, deductibles, and non-covered services that have not been satisfied, are the responsibility of the patient. Payment is expected at the time services are rendered.

If you have insurance with which we do not participate, payment is expected at the time services are rendered. We will provide you with an itemized receipt to submit to your insurance.

There are times when making a payment can be a financial hardship. Please advise our staff prior to your visit if you are in need of a special payment arrangement. Co-pays are exempt from this because your insurance requires you to pay your co-pay at the time services are rendered. You are required to notify us at the time of service if this is a worker's compensation or accident visit to avoid additional financial costs.

If we are your primary care physician, make sure our name and/or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.

Before making an annual physical appointment, check with your insurance company. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

Not all services provided by our office are covered by every plan. Any service determined "not covered" by your plan will be your responsibility.

A **\$10 service fee** will be charged in addition to your co-payment if not paid at the time of service or by the end of the business day.

Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 20 business days of your receipt of your bill. A **\$15.00** re-bill fee will be assessed on any outstanding balance greater than 30 days if previous arrangements have not been made. *Unpaid balances may result in the postponement of scheduled well visits.* Any balance over 90 days will be forwarded to our collection agency, Berks Credit and Collections Inc.

A **\$25.00** fee will be charged for checks returned for insufficient funds. If a check is returned, all future payments must be cash or credit.

We charge **\$20.00** to transfer medical records for the first child and **\$15.00** for each additional transfer that is requested at the same time.

If your child has school, camp, or sport forms to be completed, there is a **\$10.00** charge per form. Payment is due when the forms are dropped off. We have a 5 to 7 day turnaround time for forms. If a form is needed sooner than 3 days, there is an additional **\$10.00** *rush* fee.

I authorize treatment by the providers of Abington Pediatric Associates and assign insurance benefits for all services rendered.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this policy.

Name of Patient(s):

\_\_\_\_\_  
Guarantor's name *(Please print)*

\_\_\_\_\_  
Guarantor's Signature

\_\_\_\_\_  
Date

XXX-XX- \_ \_ \_ \_

Last four (4) digits of Guardian's Social Security Number