

Suburban Pediatrics, Inc.

Financial Policy

Thank you for choosing Suburban Pediatrics as the health care provider for your child. We are committed to providing the best quality care to each of our patients. Please understand that payment of your bill is considered a part of your responsibility in this relationship. The following is a statement of our Financial Policy to help you understand your obligation which we require you to read and sign.

Regarding Insurance

All charges will be submitted to your insurance plan provided we are a participating contract provider for that plan. If we are not a contract provider all balances will be due in full at the time of service and you will be given a copy of the bill to seek reimbursement. Copays and charges for services not covered by your insurance will be due at the time of service. Coinsurance and deductible amounts will be your responsibility.

Copays

Copays are a part of **YOUR** contract with your insurance company and by law are due **AT THE TIME OF SERVICE**. Insurance companies **do** perform random audits and if a breach of contract is found it may result in a loss of your coverage.

Minor Patients

The adult accompanying a minor patient (parent, legal guardian, grandparent, etc.) will be responsible for payment of the copay or any pre-determined charges not covered by insurance **AT THE TIME OF SERVICE**. However, in the event of a **true emergency** other arrangements will be made with the Billing Office.

Adolescent Patients

Adolescent patients not accompanied by a parent are responsible for payment of the copay or any charges pre-determined not covered by insurance at the time of service.

Separation/Divorce Policy

Suburban Pediatrics is not a party to any separation or child support agreement or divorce decree. The parent accompanying the child is responsible for paying the copay or any charges pre-determined not covered by insurance **AT THE TIME OF SERVICE**. Balances for services denied by insurance are due in full thirty days after the date of the first monthly statement regardless of the terms of the separation or child support agreement or divorce decree. It is your responsibility to keep our office informed of any address, phone number, or insurance changes as we can only work with the information provided to us.

Rebilling Fees

A \$5.00 rebilling fee will be applied to balances \$20.00 or under not paid within ten days from the date of the first friendly reminder letter from the Billing Office. A \$20.00 service fee will be charged to your account for any returned checks. If two returned checks are received on your account within a twelve month time period you will no longer be able to pay for services with a personal check. Payment will be accepted only by cash, money order, or credit card (MasterCard or Visa).

Thank you for understanding the need of a Financial Policy by our practice and assisting us in providing the best care possible for your child. Please contact the Billing Office at (314) 567-1769, Monday through Friday 8:00 a.m. - 4:30 p.m., if you have any questions or concerns.

*I, the parent of _____ have read the Financial Policy and I understand and agree to
Patient Name
these terms, and to assignment of benefits from my insurance company to Suburban Pediatrics, Inc.*

X _____
Signature of Responsible Party

Date

X _____
Signature of Responsible Party

Date