Pure Joy PEDIATRICS

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OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office financial policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please check in at the front desk and present your current insurance card upon request and update the clinic staff of any changes in insurances or pharmacy at every visit. It is the patient's responsibility to provide correct insurance information to the best of your knowledge. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician, make sure our name 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.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. It is your responsibility to understand your benefit plan. It is also your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
5. If our physician(s) do not participate in your insurance plan, payment in full is expected from you at the time of service for your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
7. Co-payments are due at time of service. A $50 processing fee (service fee) might be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB). Your remittance is due within 10 business days of your receipt of your bill.
9. If previous arrangements have not been made with our billing and finance office, any account balance outstanding greater than 28 days will be charged a $50 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
10. If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card remain on file. There are addenda to this financial policy, which are signed separately.
11. We require 24-hour notice for canceling any appointments. There is a $75 charge for weekday appointments if they are not canceled OR if 24-hour notice is not given.
12. A $75 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
13. We may charge $25 per child to copy or transfer medical records.
14. If your child has school, camp, or sport forms to be completed, there is a $25 charge per form. Payment is due when the forms are dropped off. We have a three (3) to five (5) day turnaround time for forms. If a form is needed sooner than three (3) days, there might be an additional $20 rush fee.

15. Advance notice is needed for all non-emergent referrals, typically three (3) to five (5) business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
16. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a well health visit. Not all plans cover annual well health physicals or hearing and/or 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.
17. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

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 previously.

Patient Name(s): _____

Responsible party member's Name Relationship

Responsible party member's Signature Date

Credit Card Payment Authorization:

By checking "Yes", you agree to add and save your credit card information for the sole purpose of the above via the patient portal after your first online payment and I authorize Pure Joy Pediatrics, LLC to keep my credit card information on file...

○ Yes

… and by signing below, you understand that you give Pure Joy Pediatrics, LLC permission to debit your account on or after the indicated date. This will serve as a permission for as needed transaction(s) for fees associated to services rendered, but not to exceed $250 without prior approval, including but not limited to, all appointment fees, no show fee, late cancellation fee, off hour telephone/telemedicine call fee, etc. I also give Pure Joy Pediatrics, LLC permission to bill my credit card on file if an invoice is not paid after 10 business days of submission. It is the responsible party's responsibility to notify Pure Joy Pediatrics, LLC of any changes to their credit card and/or debit card information.

Responsible party member's Signature Date