Mansfield Pediatrics
OFFICE FINANCIAL POLICY

Please read the following carefully and direct any questions you may have to the front office staff.

PAYMENT FOR SERVICES WITHOUT HEALTH INSURANCE:
Payment for services is due on the day of your child's visit. Our cash prices are based on an insurance reimbursement average.

PAYMENT FOR SERVICES USING HEALTH INSURANCE:
Please sign in at the front desk and present your child's current insurance card at every visit. This is your verification of the correct insurance and consent to bill for services on your child's behalf.
IF THE INSURANCE PLAN THAT YOU DESIGNATE IS INCORRECT OR NOT IN FORCE, THEN YOU ARE RESPONSIBLE FOR PAYMENT OF THE VISIT AND YOU WILL BE BILLED FOR THE VISIT UNTIL YOU PROVIDE THE CORRECT INSURANCE PLAN INFORMATION FOR THE OFFICE TO FILE FOR PAYMENT OF SERVICES. THIS INFORMATION MUST BE RECEIVED WITHIN 30 DAYS OF THE DATE OF SERVICE DUE TO INSURANCE FILING DEADLINES. . . NO EXCEPTIONS!

Some insurance plans will not pay for services unless your child's physician is designated as his Primary Care Provider (PCP). Make sure that your child's physician's name or phone number appears on your card and /or the insurance company has been informed of your child's PCP name as of the date of service, **OTHERWISE YOU ARE RESPONSIBLE FOR PAYMENT OF THE VISIT.**

IF YOUR CHILD'S PHYSICIAN DOES NOT ACCEPT OR PARTICIPATE IN YOUR INSURANCE PLAN, PAYMENT IN FULL IS EXPECTED AT THE TIME OF YOUR CHILD'S VISIT.

If you participate in a **HIGH DEDUCTIBLE HEALTH PLAN**, you are required to **PAY IN FULL THE ALLOWED AMOUNT ON YOUR INSURANCE UNTIL YOUR DEDUCTIBLE IS MET.**

COPAYMENTS:
Co-payments are due AT THE TIME OF SERVICE and are collected at **CHECK-IN** at the front desk.
THE PARENT, LEGAL GUARDIAN, AUTHORIZED RELATIVE OR OTHER AUTHORIZED ADULT WHO IS ACCOMPANYING THE CHILD IS RESPONSIBLE FOR PAYING THE CO-PAY ON THE DAY AND TIME OF SERVICE.
COPAYMENTS MAY NOT BE WAIVED.

SERVICES AND BENEFITS COVERED BY HEALTH INSURANCE PLANS:
You are responsible for knowing what benefits and services your health insurance covers for your child. Insurance benefits **VARY WIDELY**. **Not all services provided in the office are covered by every insurance plan.** For example, some plans do not cover well child visits at all or have a limited maximum amount for well child care per year, or cover only immunizations required by the state. Please check with your insurance plan before scheduling annual health check-ups especially after the age of 4. NOTE: Some annual well child check-ups are covered once every 365 days whereas other health plans allow 1 well child check-up per calendar year.

SERVICES AND BENEFITS COVERED BY HEALTH INSURANCE PLANS – Cont.:
This office does try to verify your child's insurance coverage and benefits several days in advance of your child's scheduled well child visit, but Y**OU ARE ULTIMATELY RESPONSIBLE FOR PAYMENT OF SERVICES DETERMINED NOT TO BE COVERED BY YOUR PLAN.**

BALANCES AND BILLS:
You will be advised of any outstanding balances due when you **CHECK IN AT THE FRONT** desk for your child's visit. Payment of outstanding balances **MUST BE ADDRESSED** prior to your child's visit. Balances are billed immediately on receipt of your insurance plan's explanation of benefits (EOB) by the billing department. Your bill is due upon receipt of your bill by mail. Please contact the billing office at the number on your statement to discuss bills, balances and payment questions during office business hours.

NON-SUFFICIENT FUNDS CHECKS:
Please save everyone time, money and embarrassment by not writing a potential NSF check.
Please inform the front desk receptionist of any problem you have making proper payment and let her assist you.

There is a $35.00 fee for each check returned for NSF or any other reason AND you will need to pay with cash or valid credit/debit card for any visits in the future.

MISSED APPOINTMENTS:
As a courtesy to other families in the practice who may need appointments for sick children, please give at least 24-hour notice to the office when you will not be able to keep an appointment previously scheduled. **Missing 3 scheduled appointments without prior notice to the office may be grounds for your child's dismissal from the practice.**

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

Patient Name(s)____ Date____________________

____ Date____________________

____ Date____________________

____ Date____________________

Parent Name(s) (printed)

Mom____

Dad____

Parent Signature____

Relationship to child/patient____ 12/21