Financial Policy

Thank you for choosing The Children's Clinic as your child's healthcare provider. We are committed to providing your child with the highest level of care in a warm and loving atmosphere. To be clear and eliminate confusion on payment for services, we have adopted the following financial policies. Please read them carefully and feel free to ask questions if any part is unclear. As always, we are willing to work with you, if there are special financial circumstances.

Payment for Services:
Payment is required at the time services are rendered. Regardless of your insurance coverage, you are ultimately responsible for full and timely payment of all charges incurred at The Children's Clinic. If you fail to make payment in full or prior financial arrangements with our billing manager, any overdue balance on your account may be sent to an outside collection agency which may result in your termination from our practice. You will be responsible for any additional fees charged by the collection agency.

If you receive a statement from our office, payment in full is expected at that time. If you cannot pay the entire balance due, please contact our billing manager to set up payment arrangements.

Please note that whoever brings the child in for the visit (i.e. grandmother, aunt, etc.) is responsible for any co-pays, coinsurance and deductible amounts due at the time of service.

The Children's Clinic will not be involved in parental billing and/or custody disputes.

Insurance:
We have established payment contracts with several insurance carriers. This means we will file your insurance claims for you and accept their allowable amount as our full charge for those services. The only secondary insurance we file is Blue Cross Blue Shield.

Missed Wellness Appointments:
It is important to keep your scheduled wellness appointments. These time slots are longer than those of a sick appointment so you and your child's doctor have plenty of time to discuss your child's growth and development and any concerns you may have. If you need to cancel or reschedule a wellness/checkup appointment, please do so 24 hours prior to the appointment time so another child can be scheduled in that slot. Failure to give proper notice of cancellation may result in assessment of a $25 no show fee. Patients that accrue three no-shows for wellness appointments may be discharged from the practice.

Please see reverse side and sign back.

INSURER/GUARANTOR RESPONSIBILITIES

- Be familiar with the requirements of your specific plan. Please make yourself aware of any non-covered services with your carrier prior to your visit.
- Present your insurance card at every visit.
- Pay your co-pay, coinsurance and/or deductible at each visit. Payment can be made by check, cash or credit/debit card.
- Notify the front office or billing staff of any changes to your health insurance prior to services being rendered; otherwise, full payment for services will be expected from you at the time of service.
- Services deemed as "non-covered" by your insurance carrier are not written off and you are responsible for payment in full.
- Specific coverage issues should be directed to your insurance company. If you have any insurance or billing questions our billing staff will be more than happy to help.

Communication and Authorization: I hereby authorize and consent to the release of all medical and personal information (including but not limited to my home, cell and work phone, address and email address) by or to all the healthcare professionals involved in my care; Interpretation of test results; account billing and collections; payment posting and/or processing; or related healthcare functions. This authorization shall remain in effect until such time as all account balances extending from the encounter have been fully satisfied.

I authorize all clinical providers who have provided care or interpreted my tests, along with any billing service and their collection agency or attorney who may work on their behalf, to contact me on my cell phone and/or home phone using pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication.

Acknowledgement and Acceptance of Financial Policy: I agree to the above terms of this financial policy and understand that it may change at any time without written notice. I further understand that whoever brings my child in for visits is authorized to receive financial and medical information on my child and will be responsible for paying any co-pays or deductibles due at time of service. I also agree that if my child is over the age of 18 I will continue to accept financial responsibility until they no longer receive services at The Children's Clinic. I understand this authorization will remain effective until I provide written revocation.

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Signature of Patient or Responsible Party Date

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Printed Name of Responsible Party Relationship to Patient