PEDIATRIC ASSOCIATES – Fairfield-Hamilton-West Chester-Harrison
FINANCIAL POLICY – May 15, 2017

Patient Name: _____DOB: _____Acct. #_____

Thank you for choosing us as your child's health care provider. We appreciate your trust and we are committed to providing quality health care to all of our patients. As part of our service to you, we try to contain the ever-rising cost of health care and feel that it is important for our patients to understand their financial responsibilities. The following is a statement of our Financial Policy, which we require that you read and sign prior to your first visit with our practice.

All responsible parties must complete and sign our Patient Information Form before seeing a provider. You will be asked to verify and sign this form prior to each subsequent visit unless you have changes that need to be made. If changes have occurred you will be asked to complete a new form.

Our payment policy is as follows:

If we are participating providers with your primary insurance company, we will file your claims. If your insurance plan requires a co-pay, that payment is expected at the time of service. If not, a $10 administrative charge will be added to your account. Any attorney or collection fees incurred due to delinquency in payment will also be charged to your account.

FULL PAYMENT IS DUE AT TIME OF SERVICE IF YOU ARE UNABLE TO PROVIDE PROOF OF INSURANCE COVERAGE OR WE ARE NOT CONTRACTED WITH YOUR INSURANCE CARRIER.

WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER AND AMERICAN EXPRESS.

Should you choose to make payment ONLINE - this financial form authorizes us to collect payment electronically and send receipt of payment to the email address you provided to us.

Sometimes services billed to your insurance carrier are "pended" with a request for additional information from the insured. If you do not respond to your carrier's request for the information needed to process your claim you may be billed for these services.

Please be aware that we perform only services that are considered medically necessary. However, certain services may be considered "non-covered" according to your policy. These services will become your responsibility if denied by your insurance.

*****I understand that my child will remain on my account until 21 years of age and I agree to remain financially responsible unless I notify PAF in writing otherwise.*****

MISSED APPOINTMENTS

We require a 2-hour cancellation notice. This will enable us to better service all of our patient's needs. Missed appointments without the appropriate notice will result in a **$40 patient charge** for each appointment missed. CareSource/Medicaid will require a waiver to be signed along with payment. PAF reserves the right to discontinue services to any family with 2 or more missed appointments.

I UNDERSTAND AND AGREE TO ABIDE BY THIS FINANCIAL POLICY

X_____DATE_____

Signature of responsible party

Rev. 7-2017