

# **SOUTH SUMMIT PEDIATRICS**

## **FINANCIAL POLICY AND AGREEMENT**

Thank you for choosing South Summit Pediatrics as your healthcare provider. We are committed to excellent patient care. The following is an explanation of our financial policy and agreement, which you must read and sign prior to any medical evaluation or treatment.

1. Each patient's parent/ parents/ legal guardian are responsible for his/her dependant's bill.
2. Payment of all insurance co-payments and deductibles are required at the time of service.
3. Patient's parent/ parents, legal guardian who have no insurance for their dependant child are required to pay for their visit at the time of service in full. If this is not possible, you will need to make payment arrangements with our office prior to services being rendered. We accept cash, checks (In some instances checks can not be accepted), Visa, MasterCard, Discover and American Express. A \$20.00 fee will be charged on all returned checks by our office in addition to any charges applied by our check collection agency.
4. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy, this office will submit bills to you insurance carrier. In order to facilitate claim processing, you must provide all insurance policy information and changes to our office. Your bill is your responsibility whether your insurance carrier pays or not. At times, you may need to contact your insurance carrier regarding slow or non-payment of your insurance claim.
5. You are responsible for knowing what your insurance coverage is and what provider network(s) are covered under your health insurance plan. Any service provided by our medical staff, but not covered by your insurance carrier is your responsibility to pay. Be aware that some simple and minor medical services such as, but not limited to impacted ear wax removal, casting, sutures, wart removal, mole removal, skin tag removal, circumcisions, ingrown toenail removal and frenectomy (tongue clipping for children who are tongue tied) are considered under your surgical benefit by most insurance plans. Which, may result in charges being applied to your deductible and in some cases not covered at all. It is not the responsibility of our office to inform you of your plan coverage as it is impossible for us to know each and every plan out there.
6. You are responsible for any laboratory service performed at this facility that are required to be sent out to an outside third party laboratory for processing. All billings for laboratory services are generated through the lab itself; we do however provide your personal and insurance information to the lab for billing purposes only.
7. If for any reason, if collection of unpaid bills becomes necessary, the responsible party agrees to pay an additional 50 % of the owing balance as a collection fee, and all legal fees of collection with or without suit including attorney fees and court costs.
8. If for any reason your account shows that you are owed a refund, be aware that it may take 60-90 days for processing of that refund.
9. Be aware that we may charge a \$25.00 fee for no-showed appointments.
10. Be aware that we may charge a \$25.00 fee for appointments canceled without adequate prior notice. Appointment's canceled one hour or less before your scheduled appointment time will have this fee applied.

### **Usual and Customary Rates**

Our rates for medical services reflect the usual and customary rates in your community.

### **Authorization to Pay Benefits**

I further authorize and direct said agency, attorney or insurance carrier to pay from the proceeds of benefits of recovery or insurance payments in my dependant's case, directly to medical providers at South Summit Pediatrics, for their professional services rendered. I understand that this in no way relieves me of my personal responsibility for paying my dependents medical provider in a timely manner.

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Signature of Responsible Party

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Date