All Care Pediatrics PA
PATIENT FINANCIAL POLICY

Insurance: We participate with most major insurance plans. Knowing what benefits your insurance plan provides for you is your responsibility. Please contact your insurance company with any questions.

a. **IF WE PARTICIPATE WITH YOUR INSURANCE CARRIER**, all services provided in our office (unless otherwise indicated) will be submitted to your insurance.
b. **IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER, IF WE CANNOT VERIFY INSURANCE COVERAGE, IF YOU DO NOT HAVE HEALTH INSURANCE OR IF WE ARE NOT YOUR PRIMARY CARE PHYSICIAN (PCP) AND YOU STILL CHOOSE TO BE SEEN,** payment in full is expected from you at the time of your visit.

Proof of Insurance: All patients must complete our patient registration form before seeing the doctor. Photo identification and a current valid insurance card are required at every visit to provide proof of insurance. It is your responsibility to verify that the office staff has the most current and correct information regarding your health insurance policy. Failure to provide current information may result in non-coverage for services provided, and the resulting charges will be your responsibility.

Out-of-Pocket Expenses: Certain office procedures or services may not be covered or may be applied to your deductible or co-insurance. Copays, deductibles and past due balances are due at the time of service. Copays not paid at the time of service are subject to a ten dollar ($10.00) surcharge. Patient balances will be billed within thirty days after receipt of the insurance company's payment. Although we do not mail statements with balances less than five dollars ($5.00), the patient will still be responsible for payment as it will reflect on their account.

Divorce/Child Custody Cases: The guardian who accompanies the child is responsible for payments due at the time of service. It is the parent's responsibility to first make the appropriate payment to us when services are rendered. We are not party to divorce judgements.

Delinquent Accounts: You will be billed an additional Collection Fee of fifty dollars ($50.00) or 20% of the balance owed, whichever amount is greater, if your account is referred to an outside agency or attorney for collection.

Extended Payment Arrangements: We offer "Easy Pay," a credit card payment service. All arrangements must be addressed to a Patient Account Representative.

Return Check (NSF) Fee: A fee of thirty-five dollars ($35.00) will be charged for all returned checks.

Credits: If an account acquires a credit, the patient will be notified. The patient will have the option to have a refund issued, or keep the credit on the account to be applied toward the next visit.

Missed Appointments: Failure to cancel your appointment without at least 24 hour notice from your scheduled visit will result in a fee of twenty-five dollars ($25.00).

I, the undersigned, give my authorization to treat and assign directly to All Care Pediatrics PA all medical benefits, if any, otherwise payable to me, for services rendered. I understand that I am ultimately financially responsible for all charges, whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the Practice to use and disclose my health insurance information for purposes of treating me/my children, obtaining payment for services rendered to me/my children, and conducting healthcare operations.

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Patient Signature or Parent/Guardian Signature Date

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Patient's Printed Name

Revised: January 2023