



## Office Financial Policy

### Insurance:

It is the parent or guardian's responsibility to provide the most current insurance information at every office visit. You will be asked to present the card upon arrival along with any co-pay or outstanding balance. As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. If you have no insurance, full payment is due at your appointment.

### Financial Arrangements:

Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept cash, check, and credit card (Visa, Mastercard or Discover). Returned checks will be subject to a \$20 returned check fee. If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment. We are happy to offer an option to keep your **Credit Card on File** in a secure databank. See below for our Credit Card on File Policy. If you find that you have a balance that is difficult for you to pay in one or two installments please contact our office to make payment arrangements. As long as you are able to keep our arrangements, we will be able to defer any billing fees.

### Patient/Parent/Guardian Responsibility:

- At the initial visit you may sign our consent for minor treatment form that allows us to render care at follow up visits without the presence of a parent or guardian. I understand that whoever accompanies my child to their appointment has authorization to consent to medical care as needed, and is responsible for payment of medical services. Adults accompanying patients are asked to pay for the child's healthcare *at the time of service*. This includes but is not limited to: co-pays, outstanding co-insurance amounts, outstanding deductible amounts, outstanding non-covered services or any other outstanding balance at the time of service.
- I acknowledge my responsibility for payment of all services provided in accordance with the practice's fees and terms. Sometimes a child is brought to the office for a Preventative/Well Child visit and will present with a complaint of illness, or symptoms of an acute problem will be found on examination. In this situation, you will be billed for both the Preventative and sick visit as allowed by national guidelines established by the CMS and the AMA. You may be charged a co-pay, co-insurance or deductible as your contract with your insurance carrier states.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment. We are sensitive to the fact that sometimes agreements are made between parties during a separation or divorce regarding the responsibility of payment for healthcare. We do not split bills for services. We hold to our policy that the accompanying adult will pay for services that day and/or any outstanding balance. For your convenience arrangements can be made with our office to keep a credit or debit card on file to make the necessary payment at the time of service. See our Credit Card on File Policy below.

### Late Fees:

I understand that my account becomes delinquent if not paid within 30 days after a billing statement is rendered and the unpaid balance becomes subject to a monthly finance charge of \$15. Any further delinquency may warrant the balance and any administrative fees being assigned to a collection agency.

**Missed Appointments/Cancellations:**

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. For cancellations, 24 hours prior to appointment is requested. A \$25 fee will be charged to credit card on file for no show appointments. Three no show appointments may result in dismissal from practice.

**Assignment and Release:**

I authorize payment to be made directly to Denise Woken MD Pediatrics by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

**Credit Card on File Policy**

Denise Wolken MD Pediatrics is committed to making our billing process as simple and easy and hopefully as paperless as possible. We ask that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will store your card number in a secure, compliant location in your electronic medical record. For security reasons only the last four digits will be visible to our staff. Credit cards on file will be used to pay copays when you are seen in our office, and for account balances AFTER your insurance processes your claim.

For billing convenience, we provide the following options, please select ONE:

- Please DO NOT send me any statements for any balance due. I authorize this provider to charge my credit card automatically for all costs incurred by me for the above name provider. I understand and agree that these charges may be for, but not limited to, any deductibles, co-payments, co-insurance, missed/failed appointments.
- Please DO send me statements for any balance due. I agree to pay for all of my services at the time of service. However, if I fail to pay my account balance within 60-days, then I understand and agree that the full balance owed will be charged to my credit card. I understand and agree that these charges may be for, but not limited to, any deductibles, co-payments, co-insurance, missed/failed appointments or any balance owing more than 60-days old.

If your credit card payment is declined, we will call you. If our reminder call is not returned within one week, a \$20 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of \$20. Further delinquency will be subject to collections with additional finance fees.

I give Denise Wolken MD Pediatrics permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

I understand that this payment authorization shall remain valid unless revoked in writing. Should my credit card be declined for any reason, I agree to promptly remit payment in full by cash, check or money order.

**Past Due Accounts:**

Failure to pay after services are rendered may result in dismissal from practice.

**Name (please print):** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Signature of Responsible Party (Guarantor):**

\_\_\_\_\_

**Relationship to Patient(s) (please check):** \_\_\_ Self \_\_\_ Other: \_\_\_\_\_

**Note:** The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.