Milestone pediatrics

Patient Name: _____
Date of Birth: _____

PRACTICE FINANCIAL POLICY

Please review and acknowledge below.

- Co-payments for office services are required at the time you check-in.
- As a courtesy, we will process and file your insurance claims for services at no cost to you.
- For services that are covered by insurance, the practice requires payment of approximately 20% of the total estimated charges or the co-payment specified by your insurance.
- For services that are not covered by insurance, the practice requires payment of 100% of total charges unless payment arrangements have been worked out.
- Returned checks are subject to a handling fee of $20.00. In the event your account must be turned over for collection, you will be billed and are responsible for all fees involved in that process.

You must realize that:

1. Your insurance is a contract between you and your employer and/or the insurance company. While we may be a provider of services, we are not a party to that contract. We encourage you to contact your insurance carrier personally in order to remain informed of your benefits.

2. Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover or which they may consider medically unnecessary, and, in some instances, you will be responsible for these amounts. We will make every effort to ascertain your coverage for our services before treatment and will make you aware of our findings. However, this does not guarantee payment from your insurance carrier.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. We will allow you 90 days to pay any balance remaining after insurance payment. After that time, your account will accrue interest at the rate of Prime plus 2%. Our staff will make arrangements for you to make monthly payments over an approved term. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please do not hesitate to ask us. We are here to help you.

PLEASE READ THE ABOVE CAREFULLY BEFORE SIGNING. By signing below, I acknowledge that I have read and understand this policy.

Signature:_____ Date:_____
(Parent/Guardian or Responsible Party)

Milestone Pediatrics
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