If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt or your bill.

If previous arrangements have not been made with our finance office, any account balance outstanding longer than 28 days will be charged a $10 re-bill fee for each 28-day cycle. Any balance outstanding longer than 90 days will be forwarded to a collection agency.

For scheduled appointments, prior balances must be paid prior to the visit. We accept cash, checks, Visa, and MasterCard credit and debit.

A $25 fee will be charged for any checks returned for insufficient funds.

Initial:_____

Forms: We charge $10 for completing any form and a 3 day turnaround time. Payment is due when the forms are dropped off.

Initial:_____

Transfer of Records: If you transfer to another physician, we will provide a copy of your child's record, free of charge, as a courtesy to you. We need 48 hours notice. We provide records of your child for visits (including consultations from specialist) rendered at Mt. Sterling Pediatrics/Morehead Pediatrics only. For any previous records, you must request them directly from your previous doctors.

Initial:_____

Referrals: Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember, we must approve referral before they are issued.

Initial:_____

Prescription Refills: For monthly medication refills, we require 48 hours notice, during regular business hours. Please plan accordingly.

Initial:_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name_____

Responsible Party Member's

Name_____ Relationship_____

Responsible Party Member's Signature_____ Date_____

mt. sterling pediatrics

morehead pediatrics

Office Policy

Our goal is to provide and maintain an excellent physician – patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments: We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate a 24-hour notice; we reserve the right to charge $20 for a missed appointment.

If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may be necessary to reschedule you appointment.

Three missed appointments are grounds for **termination** as a patient.

We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit.

Initial _____

Insurance Plans: It is ***your responsibility*** to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

If we are your primary care physician, make sure our name appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you may be financially responsible for your current visit.

It is ***your responsibility*** to understand your benefit plan with regard to, for instance, covered services and participating laboratories. For example

A. Not all plans cover annual healthy (well) physicals, sports physicals, or hearing and vision screening. If these are not covered, you will be responsible for payment.
B. For children younger than 2 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

It is your responsibility to know if a written referral or authorization is required to see specialists whether prior-authorization is required prior to a procedure, and what services are covered.

Initial:_____

Financial Responsibility: According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co-payments are due at the time service and are contractual agreement between you and your insurance. We are required to collect co-payment at the time of service. I understand that I am responsible for any balance not covered by my insurance.

As a reminder, a portion of the cost of your child's visit is determined by the time and complexity of the visit with you and your child. If cost is a concern please keep this in mind.