



Patient Financial Responsibility Agreement

We value the relationship we have with you and your children. Advising you in advance of our office policy for financial obligations allows for a good flow of communication. Please read and sign this agreement. If there are questions regarding any of this content, please do not hesitate to ask a member of our billing team.

Patients without proof of insurance, which is required at time of service, or patients who owe a prior balance are required to pay in full before service. Cash, check, Visa, Discover, Mastercard and American Express are all acceptable forms of payment. Sometimes the charge for a service cannot be determined until after the appointment, in which case, arrangements will be made to pay for the service after it is performed.

Patients with Insurance coverage:

We will be glad to help you obtain the appropriate benefit from your insurance carrier and bill your carrier as a courtesy to you. However, you are responsible for the payment of your account and responsible to resolve any problems with your insurer. It is also your responsibility to notify us of any changes to your insurance policy.

Also, please note, that although we may be participating with a certain carrier, your plan may specifically require a certain specific network of doctors/facilities within THEIR healthcare network to be used. This can occur sometimes for special contracted companies or certain discounted plans. It is the responsibility of the patient/and or parents/guardians/subscriber to know the rules of your insurance plan. We can help you understand the rules but the insurance company will be the main source of information for your plan.

If your plan requires a Primary Care Physician (PCP) on your policy, each subscriber must have our office listed as the PCP. Our name should appear on the insurance card. If it does not, contact the insurance because we will not receive payment for your services and/or the referrals we issue for you will not be valid.

High deductible plans and co-payments

Portions of the bill may not be paid by the insurance company and are to be paid by the patient. Many times there is a co-payment (or co-pay) required by you as per your insurance agreement. The co-pay, according to insurance guidelines, is to be paid at the time of service. **Please note that you are responsible for deductibles, co-insurance, co-pays and non-covered services.** We request that if you have a flex spending or HSA account, we will keep this information securely on file.

Outstanding balances

Patient bills are generated upon receipt from your insurance carrier. If there is a credit on your account, it will be applied to your balance. The outstanding amount of the bill is expected within 10 days of the receipt of your bill. Any account balance outstanding more than 30 days will be charged additional finance charges and subsequently forwarded to our collection agency. Once the bill goes to the collection agency, our office will send you a formal notice of patient termination. Once this notice is sent to the parents/guardians, the patient will be unable to receive medical care from this office after 30 days. This would include prescription refills, order fulfillment and/or after hour calls.

****Any account balance over 90 days old will receive a certified letter and will need to be settled in 10 days. If payment is not received or arrangements made, we will assume you no longer want your child seen at Next Generation Pediatrics. Your account will be sent to collection, and all legal fees and collection expense will be added to your balance. By law, we will continue to provide emergency care for 30 days from the date of notice. Should a patient need non-emergent medical attention in those 30 days, you will be required to settle your account prior to the visit.****

Physicals

Preventative visits are extremely important in the care of your children. According to the American Academy of Pediatrics it is of great importance in comprehensive health supervision, the continuity of care each child so deserves. This is why our practice follows the AAP's recommendation stating each child be seen annually for a check-up exam. Your care team may determine when these types of visits are necessary; however, some insurances do not cover annual health physicals, hearing and/or vision screenings. Also, some cover only once in a certain time period (i.e. calendar year). Again, we will do our best to determine the level of coverage available to your child, however, the insurance company is the best source of information for you. If it is determined that the visit may not be covered, we request payment at the time of service. If a patient is seen for an annual physical and a problem is discovered or a pre-existing problem is addressed at the same time of service, additional charges may be applied at the visit whereas the patient would be responsible for co-pays, deductible or co-insurance.

Additional Terms:

- **Evening code, 99051, is a billable code per insurance, to all 5pm or later, weekend & holiday appointments.**
- **Co-pays are due at the time of service.**
- **There is a \$15.00 no-show fee for those who do not show up for their scheduled appt. (this does not apply to those who call us to reschedule or cancel the appt).**
- **Checks returned by your bank are subject to \$25.00 finance charge as well as any bank fees incurred.**
- **If a form needs to be completed (outside of a scheduled physical) there will be a \$10.00 charge per form needed.**
- **This office reserves the right to discharge a patient from the practice if the financial policy is not followed.**

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

***I agree and comply with the American Academy of Pediatrics recommendation that my child / children will be seen annually for a check-up exam.**

***I also agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in a charge to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using prerecorded / artificial voice messages and/or use of an automatic dialing device, as applicable.**

***I / We have read this disclosure and agree that Next Generation Pediatrics may contact me / us as described above.**

Patient Name(s) _____ Date _____

Responsible party's name (print) _____ Signature _____