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Tel:(407) 910-2340 Fax: (407) 237-0944

OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance on our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please check-in in the front desk and present your current insurance card at **every visit.** You will be asked to verify and sign that the information printed on your child's forms is correct. This is your verification of the correct insurance and consent to bill them on your child's behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. We do not submit to secondary insurance plans. If you have a secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.**
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if a preauthorization is required prior to the visit.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at time of service.
9. 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 of your bill.
10. **Non-payment and Overdue Accounts:** Any outstanding balances on your account are expected to be paid in 28 days. If payment is not received we will assume you no longer want to have your children seen at Little House Pediatrics and you will be discharged. Your account will be send to collection and all additional fees will be added to your balance. By law we will continue to provide emergency care for 30 days from date of notice.
11. We require 24-hours cancellation notice to avoid a fee. There is a **$40.00** charge for missing appointments. Medicaid patients might be discharged if more than 2 appointments are missed and 24-hour notice is not given, as government rules prohibit this fee to Medicaid patients.
12. We charge **$1.00** per page for the first 25 pages and **0.25¢** for each additional page to copy medical records.
13. If your child has school, camp or sport forms to be completed, there is a **$5.00** charge per form. Payment is due when the forms are picked up. We have a 3 to 5 day turnaround time for forms. If a form is needed sooner than 3 days, there is additional $5.00 rush fee. One (1) school, sport or camp form will be provided at no charge at the time of the Well Child Visit, if the form is not requested during this visit, the above charges apply.
14. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
15. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand Little House Pediatrics financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

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Name and Signature of Patient/ Parent/Legal Guardian Date