EASTERN PEDIATRICS, P.A.
913 East Arlington Blvd • Greenville, NC 27858 • Phone: (252) 561-7777

FINANCIAL POLICY 2017

We are pleased that you have chosen Eastern Pediatrics, P.A. to provide your medical care. Our practice is committed to providing your child with the best possible medical care. We believe that a good physician and patient relationship is based on understanding and good communication. Therefore, we want to communicate our Financial Policy to you in writing so that you know what to expect at the time of your visit. We are doing all we can to hold down the cost of medical care and you can help us by eliminating the need for excessive billing.

Please be prepared to pay for services when services are rendered. This includes applicable co-insurance, deductibles, and co-payment amounts for insurance we are participating with. We accept cash, personal checks (in-state only), Visa and MasterCard. We do not accept post-dated checks. There is a $30.00 fee for returned checks. If co-payments are not paid at the time of service you may be charged a fee of $20.00 or more depending on your insurance.

Insurance

As a courtesy to you, we will be happy to bill your insurance company. However, there may be a portion of the bill that is your responsibility. If you are unable to pay your bill at the time of service, please ask to speak with our Financial Advocate in advance. He / she will assist you with arranging a payment plan, or rescheduling your appointment for a time when you are more prepared to pay. If we have not received payment from your insurance within 45 days from the date of service, you will be responsible for the balance in full. We will be glad to bill your secondary insurance, but you will need to give the updated information to the receptionist at the time of your visit. We will not go back and file insurance retroactively. If you have insurance that we do not participate with, our office will gladly file the claim, however payment in full is expected at the time of service.

Balances

Balances not paid within 90 days are considered delinquent unless a payment plan has been arranged in advance. Accounts 90 days past due will be turned over to a collection agency and late fees will be assessed. We reserve the right to terminate patients with bad debt.

Canceled, Late, and Missed Appointments

Missed appointments are costly to our practice, to you and to the other patients needing an appointment. If you must cancel your appointment, kindly give us a 24 hour notice. **We reserve the right to charge a fee of $40.00 for missed or late cancelation of appointments.** Continued excessive abuse of unfulfilled scheduled appointments may result in discharge from our practice. **If you arrive 15 minutes or later beyond your scheduled appointment time, we reserve the right to reschedule your appointment and a fee of $40.00 will be charged.**

Managed Care/HMO Plans

If you are enrolled in a managed care insurance plan (HMO), you must receive a referral/authorization from our office **prior** to seeing a specialist. **No retroactive referrals will be issued.**

Financial Difficulties

We realize that financial hardships may occur, but we ask that you contact our Financial Advocate in advance to arrange a payment plan and discuss your financial situation so that we can continue to provide care for your child or children when they need it. Please call our Billing Office between 9:00 AM and 4:30 PM, Monday through Friday at 252-561-7777 if you need help with your account.

Overpayments

Overpayments will be refunded upon written request to the responsible party within 30 days.

Financial Agreement

I have read and understand the Eastern Pediatrics Financial Policy. I acknowledge that payment is due at the time of service unless other arrangements are made in advance. I agree that parents/guardians are responsible for all charges and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I understand that I am responsible for all charges regardless of insurance payment.

_____ _____

Date *Signature*

Assignment of Benefits

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of my dependents. I further agree and acknowledge that my signature on this document authorizes my physician to submit claims for benefits for services rendered and that insurance benefits will be paid directly to Eastern Pediatrics, P.A.

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Date *Signature*