Patient Name: _____D.O.B.: ____/_____/_____

EASTERN PEDIATRICS, P.A.

Financial Policy 2024

Thank you for choosing Eastern Pediatrics as your child's health care provider. The following is a copy of our financial policy. Patient care is not permitted without the written consent of the receipt and acknowledgement of the understanding of this policy.

Payments: Payment, in full, is due at the time of service. This includes applicable co-pays, co-insurance, deductibles and payments for services not covered or denied by the insurance company. Eastern Pediatrics accepts cash, personal checks, debit cards, major credit cards **except** Discover & American Express. There is a **$35.00 fee** for returned checks and stop payments. **_____(initials)**

After hour service fee: A $25.00 service fee will be charged for all after hour phone calls to the on-call provider for medical advice. _____ **(initials)**

Medical Records fee: A $25.00 service fee will be charged **per patient** for **ALL** out going medical records. **_____(initials)**

Self-Pay Accounts: If you do not have insurance, please come prepared to pay for your visit in full upon check-in. We offer a 20% discount for all self-pay services paid in full on the day of the service. **_____(initials)**

Insurance: We accept most insurances including most Medicaid plans. Please contact your insurance company to verify we are listed as a contracted provider before scheduling an appointment if you are unsure. As a courtesy to you, we will be happy to file a claim to your insurance company; however, there may be a portion of the bill that is your responsibility which will be due at the time of service. **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 an insurance plan that we do not participate with, our office will gladly file the claim, however, payment in full is expected at the time of service. Please bring a copy of your insurance card to every visit. **_____(initials)**

Change of Insurance/Change of Account Information: Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges. **_____(initials)**

Missed Co-Pays: Eastern Pediatrics is required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays puts the responsible party and Eastern Pediatrics in default of the insurance contract. A **$25.00 service fee** will be charged in addition to your co-payment, if the co-payment is not paid by the end of that business day. **_____(initials)**

Patient Name: _____D.O.B.: ____/_____/_____

Canceled, Late, and Missed Appointments: Missed appointments represent a cost to us, you, and to other patients that could have been seen during the time set aside for your child. If you must cancel your appointment, kindly give us a 24-hour notice. **A 'no show" fee of $80.00** will be applied if an appointment is missed and not cancelled within the stated time frame to your account. If you arrive 5 minutes or later beyond your scheduled appointment and/or you arrive more than 5 minutes late for your **SAME-DAY** appointment, we reserve the right to cancel your appointment and a fee of **$80.00** will be charged to your account. **_____(initials)**

Outstanding Balances: If you have a personal balance on your account, a monthly statement will be sent. Your payment is due upon receipt of statement or within 30 calendar days. Balances not paid within 90 days are considered delinquent unless a payment plan has been arranged in advance, your account will be turned over to a collection agency and a **collection fee of $30.00** will be applied to your account which could result in dismissal from our Practice. As a courtesy, Eastern Pediatrics may offer the assigned account holder a payment plan that are approved on a case-to-case basis. Please call our Billing Office between 9:00am-4:30pm at 252-561-7777 if you need help with your account. **_____(initials)**

Credits/Refunds: Credit balances may be applied to co-pays or other patient responsibility portion of your bill. If a refund is requested, please note that a check will be issued and mail within 30 business days. **_____(initials)**

Billing Inquiries: Questions about a bill should be directed to our billing department at 252-561-7777. If you have any questions regarding the conditions and terms outlined in this document, please call our office and request to speak with our Practice Manager.

Review and consent of this policy is required prior to services rendered

Patient's first name: _____ Last name: _____ Birth date: _____/_____/____

My initials above and signature below certifies that I have read and consent to the outlined policies and procedures.

_____ _____ Date: _____/_____/_____

Signature of parent/guardian Printed name of parent/guardian