Office Financial Policy Effective: March 14, 2024

Watch Us Grow PEDIATRICS

It is the parent or guardian's responsibility to provide the most current insurance information at every office visit. You will be asked to present a valid insurance card upon arrival and agree to pay all required co-pays and/or outstanding balances.

We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided and contact your insurance company prior to your visit if you have any concerns about coverage. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. We will assist you in obtaining your benefits if needed. If you have no insurance, full payment is due at your appointment and a Good Faith Estimate will be provided prior to your appointment.

Financial Arrangements: Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept cash, check, EFT and credit cards (Visa, Mastercard or Discover). Returned checks will be subject to a $25 returned check fee. If you find that you have a balance that is difficult for you to pay in one or two installments, please contact our office to make payment arrangements to defer any billing fees.

Patient/Parent/Guardian Responsibility

Adults accompanying patients are responsible to pay for the child's healthcare at the time of service. This includes but is not limited to co-pays, outstanding co-insurance amounts, outstanding deductible amounts, outstanding non-covered services, or any other outstanding balance at the time of service. Even in the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Sometimes a child is brought to the office for a Preventative/Well Child visit and will present with a complaint of illness, or symptoms of an acute problem will be found on examination. In this situation, you will be billed for both the preventative and sick visit as allowed by national guidelines established by the CMS (Centers for Medicare and Medicaid Services) and the AMA (American Medical Association). You may be charged a co-pay, co-insurance or deductible as your contract with your insurance carrier states.

Late Fees: You understand that your account becomes delinquent if not paid within 30 days after a billing statement is rendered and the unpaid balance may become subject to a monthly finance charge. Any further delinquency may warrant the balance and any administrative fees being assigned to a collection agency.

Missed Appointments/Cancellations: Missed appointments represent a cost to us, to you, and to other patients who could have been seen at the time set aside for you. For cancellations, 24 hours prior to appointment is requested. A $25 fee will be charged for no show appointments or less than 24-hour notification of the missed appointment.

Assignment and Release: You authorize payment to be made directly to Watch Us Grow Pediatrics by your insurance company, and you accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Past Due Accounts: Failure to pay after services are rendered may result in dismissal from practice.

Patient Name (please print): _____DOB: _____Date: _____

Name of Responsible Party (Guarantor) _____Date: _____

Signature of Responsible Party (Guarantor)_____Date: _____

Relationship to Patient(s) _____