PEDIATRIC PARTNERS OF NORTHERN KENTUCKY
FINANCIAL POLICY

We are committed to providing you with the best possible care and treatment. If you have medical insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

If your medical insurance requires a co-payment, that payment is due at the time of your visit. A $10.00 processing fee will be assessed for co-payments not collected on the date of your visit. It is our policy that whoever brings in the patient to be seen is the responsible party for payment. We understand that a divorce decree will sometimes name one parent responsible for medical bills. This however is a matter that should be resolved outside of the office so payment can be made on the date of service. We will file your primary and secondary insurance claims and your portion of the charge may be paid by cash, check, or credit card. Not all services are a covered benefit in all contracts. Therefore it is your responsibility to understand the benefits of your insurance policy.

You **MUST** bring your child(ren)'s insurance card with you to **EVERY** visit.

Returned checks will carry a service charge of $25.00.

Appointments not cancelled 24 hours in advance will be charged a $25.00 non-cancellation fee per appointment. These charges are not billable to insurance. We understand that true emergencies do arise, if you call the day of your appointment and inform us you will not be able to keep your appointment, allowances may be made. If more than 3 visits are not cancelled 24 hours in advance, you will be dismissed from the practice. There is a $40.00 additional walk-in fee if we see your child without an appointment (this includes seeing the sibling of a child that does have an appointment). Every effort is made to give you an appointment in a timely manner; however walk-ins disrupt the flow of the office and are not encouraged.

There is an additional $40.00 fee if it is necessary to see your child on a Sunday.

All balances not covered by insurance are due in full within 30 days of receiving a statement unless other arrangements have been made. If your balance goes over 90 days past due and you have not responded to our attempts to contact you, we will be forced to send your account to a collection agency. Should this occur, you agree to assume responsibility for any fees and services charged by the collection agency and you will be permanently dismissed from the practice.

Please read and sign below:

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the above information and understand it fully. I will notify this office of any changes in medical insurance or any other personal information that I have provided on the registration forms. I certify this information is true and correct to the best of my knowledge.

I hereby authorize the physician to furnish information to the insurance carrier concerning medical services rendered. I also authorize the insurance carrier to make payments directly to this office. I understand that I am responsible for any amount not covered by insurance. I agree to pay all balances due in full within 30 days of receiving a statement unless arrangements have been made in advance with our billing department.

Child's Name_____

_____ _____

Signature of Parent/Guardian Date

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