WingHaven Pediatrics Financial Policy

Please read all of the agreements below and sign at the bottom as acknowledgement of your understanding.

Due to frequent changes in health insurance coverage, we require that you provide proof of insurance coverage at each visit. If you do not have insurance, are unable to provide proof of insurance coverage, or are on a plan in which we do not participate, full payment is required at the time of your child's visit.

All co-payments and balances are due at the time of service. All co-pays and balances not collected at the time of service are subject to additional fees being charged. Please be aware that some services provided may be non-covered services and not reimbursable by your insurance. You are personally responsible for these services. For your convenience we accept cash, check, debit card, Credit cards.

Primary Insurance- services are billed by Winghaven Pediatrics for all visits. This is a courtesy to our patients, however any issues with coverage and/or enrollment is the responsibility of the subscriber of the plan. We will file claims on your behalf for all visits. If a claim is denied you will be asked to contact your insurance company to resolve the issue and if not resolved within 30 days you will be responsible for the balance due. Please note that your insurance policy is a contract between you and your insurance company.

Secondary Insurance-As a courtesy to you, WingHaven Pediatrics will file your secondary insurance. This is done after payment is received from your primary insurance. WingHaven Pediatrics policy is to file the secondary insurance one time. **If payment has not been received from your carrier within 60 days, the balance becomes immediately due and payable by the patient.**

Patient Balance-WingHaven Pediatrics sends statements to patients on a monthly basis. Payment in full is due upon receipt. Regular payments help keep our costs and your charges down. **If you are unable to pay in full, please contact our office to make payment plan arrangements. If payment is not received within 30 days and our office is not contacted a $10.00 rebilling fee will be added to each statement.**

What if I can't pay my bill? Payment plans must be set up for balances of $200.00 or more that cannot be paid in full. We ask that the balance be paid within 3 months. Failure to resolve any past due accounts, including returned checks will result in referral to a collection agency. Any family whose account is forwarded to a collection agency will be dismissed from our practice.

Well vs. Sick Appointments

If you are schedule for a preventive care/ well visit and have any other new or chronic issues there will potentially be additional charges. Some new and chronic issues may require additional time which was not scheduled and you may be asked to schedule another appointment.

What is covered during a Well Appointment?

- Checking height, weight, BMI and blood pressure
- Reviewing medical and family history
- Confirm your other care providers
- Review your preventative care needs
- Order recommended preventative labs and/or imaging
- Review and administer immunizations

What is NOT covered during a well appointment?

- Evaluation and treatment of new health issues/concerns (ie; pain, ear issues, etc.)
- Management of existing/chronic health issues (ie; ADHD/Asthma, etc.)
- Ordering lab tests or imaging for new and/or chronic conditions or illnesses
- Prescribing, refilling or adjusting medications for new and or existing health issues

Missed Appointment Policy:

It is our expectation that in four our courteous and thorough attention to your child(ren)s health care that our providers be treated with equal respect of their time when canceling appointments. We require 24 hour notice when canceling and rescheduling appointment. If 24 hour notice is not give, even if rescheduled you will be required to pay a $40.00 missed appointment fee for each patient scheduled.

If you miss 3 or more appointments you may be asked to find a new healthcare provider.

By signing below I acknowledge my understanding of the financial policies of Winghaven Pediatrics, LLC.

Patient Name

Patient/Guardian Signature

Date