



Financial Policy

EverKind Pediatrics participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what your particular benefits may be. Therefore it's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Credit Card on File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email. If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

Administrative Feeⁱ

At EverKind Pediatrics coordination of care is central to making sure that children get good quality healthcare. This means several hours are spent providing services that insurance does not pay for. Some of these services include processing various administrative requests, handling refill requests outside of office visits, performing phone consultation with other pediatric specialists, securing medical records from other providers, providing a patient portal and filling any forms needed for school or camp without charging a fee for each form. To cover that administration, we charge a small annual fee of **\$40 per child up to a maximum of \$100 per family.**

You may choose to opt out of the annual administrative fee and pay a-la-carte for these requests instead. A **\$20 fee** will need to be charged for each form request, including any school entry, annual school physical, sports and camp physical forms unless done at the well visit, in which case it is included with the exam.

No-Show Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no show fee of \$25. Repeated no-shows will result in the family being advised to transfer care out of the practice.

Divorced/Separated Parents and Custodial Arrangements

EverKind Pediatrics does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

I have read and understood the above policy and agree with it.

Signature _____

Date ____/____/____

Name _____

Relationship to patient _____