PEDIATRIC PARTNERS OF NORTHERN KENTUCKY
FINANCIAL POLICY

We are committed to providing your children 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 understanding of our financial policies.

Payments: Co-payments, deductibles or co-insurances are due at the time service is provided. A current insurance card must be presented at the time of service. If your insurance contract requires a co-pay or co-insurance, it will be collected before your child sees a provider. If your insurance contract requires a deductible, we will collect $50 at the time of service and the remaining balance is due 30 days from the invoice date. Many deductible plans cover well child care in full and for those visits no payment will be collected at the time of service.

Claims: For your convenience we will file your insurance claims. Claims are usually processed within 30 days. Our billing department will make every effort to collect payment from your insurance company, but if all attempts fail it is your responsibility to contact the insurance company. We only send you a statement after we receive an EOB from your insurance company. If a claim becomes more than 90 days old you may be asked to pay the claim while you contact your insurance company. Once payment is received from the insurance company we will refund the amount due back to you. Not all services are a covered benefit in all contracts. Therefore, it is your responsibility to understand the benefits of your insurance policy.

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 we will be forced to terminate the patient/physician relationship.

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.

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 rev120913