

Summit Pediatric Associates, P.A.
OFFICE FINACIAL POLICY

Summit Pediatrics Associates goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our Office Policy, allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions please so not hesitate to ask a member of our staff.

1. Upon arrival, please check in at the front desk and present your current insurance card at every visit. Please inform us of any changes in your personal information.
2. **It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure and what services are covered, 48 hours advance notice is required for all non-emergent referrals.**
3. **According to your insurance plan, you are responsible for any and all co-payments, deductibles and co-insurances.**
4. **If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit unless other arrangements are made. For scheduled appointments, outstanding balances must be paid prior to the visit.**
5. If you do not have insurance, payment for an office visit is to be paid at the time of the visit.
6. Co-pays are due at the time of service. A \$10 processing fee will be charged in addition to your co-pay if the co-pay is not paid at the time of service or by the end of the next business day.
7. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due **10** business days from receipt of your bill. If previous arrangements have not been made with our Finance Office, any account balance over 45 days will be turned over to a collection agency.
8. We reserve the right to charge an administrative fee per month as provided by state law for all past due balances.
9. We reserve the right to collect fees for services requested by patient that are not covered by their insurance, e.g. physicals performed outside of our posted hours.
10. **A fee of \$45.00 will be charged for appointments not cancelled at least 24 hours in advance, or if you miss a confirmed appointment.**
11. **Patients who accumulate a total of 3 NO SHOWS/SAME DAY CANCELLATIONS IN A CALENDAR YEAR, will automatically be TERMINATED from Summit Pediatric Associates as a patient. EXCEPTIONS WILL BE MADE DEPENDENT ON CIRCUMSTANCES.**
12. **Summit Pediatric Associated WILL NOT REFILL ANY PRESCRITIONS OR COMPLETE ANY FORMS IF YOUR LAST PHYSICAL IS OVER ONE (1) YEAR OLD.**
13. A \$25 fee will be charged for any checks returned to insufficient funds, plus any bank fees incurred.
14. We charge \$1.00 **per page** for Medical Record copying up to 100 pages and .25 for each additional page.
15. If your child has school forms, camp forms, sport forms, etc. to be completed, there is a **\$10** charge per form. **Payment is due when the forms are dropped off as well as a self-addressed stamped envelope.** We require a minimum **one week** turn around time for those forms.

I have read and understand the above Office Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-Responsible Party

Date _____