Tan & Garcia Pediatrics, P.C.

FINANCIAL POLICY 2024

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of our policies. Your clear understanding of our financial policy is important to our professional relationship.

INSURANCE:
Payment for services is due at the time services are rendered, except as outlined below. Insurance plans vary considerably. We are not able to guarantee what services are covered under your contracted plan. It is most accurate when you call your plan's member services department for that information. The insured person is responsible to provide ***ACCURATE*** and ***TIMELY*** insurance information. Inaccurate or untimely information results in denial or non-coverage by your insurance company, and you will be responsible for payment.

WELL CHILD APPOINTMENTS:
Please note that Insurance Companies require physicians to document "sickness encounters" even when a child is scheduled for a well child care visit.

These "sickness encounters" would include both acute illnesses, e.g., fever, earache, URI, tonsillitis, UTI and chronic problems, e.g., ADHD, behavioral issues, initiation/management of oral contraceptives, chronic abdominal pain, chronic headaches, constipation and bedwetting.

Documenting additional diagnoses would incur a copay, if required by your insurance policy, according to Insurance rules.

We ask that you please mention any concerns you may have regarding your child's health at any visit and not let these rules prevent you from discussing your concerns.

NON-EMERGENT APPOINTMENTS:
Well child exams, recheck visits, and ADD visits, etc. may be rescheduled if there are outstanding balances or if a co-pay is not paid at the time of service. If you are experiencing financial difficulty, please let us know. Health insurance is a contract between you, your employer, and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy. Refer to your member information for questions about coverage for vaccines, doctor visits, tests, referrals and pre-authorization requirements.

BILLING:
We provide you with an itemized statement each time your child receives services. We accept MasterCard and Visa credit cards. Outstanding balances are due within 30 days, unless prior arrangements have been made with our office.

- A **$10.00** fee will be charged if your co-pay is not paid at the time of service.
- A **$35.00** fee is charged for all returned checks and your account will be placed on "Cash Only" basis. We will accept payments by cash or credit card until the balance is cleared.
- A $**25.00** will be charged for "walk-in" (non-scheduled) appointments.
- A **$30.00** fee will be charged for the completion of FMLA (Family Medical Leave Act) forms.
- A **$50.00** fee will be charged for a confirmed missed appointment or appointments canceled with less than a 24-hour notice.

We realize that financial problems may affect timely payment of your account. We encourage you to contact our office promptly to work out payment arrangements. If balances become

uncollectible due to bankruptcy, we will continue to see your child on an emergency basis only for thirty (30) days giving you time to find a new source of medical care.

_____	_____
Child's Name	Parent's Signature
_____	_____
Child's Name	Parent's Signature
_____	
Child's Name	

The adult who accompanies a child to an appointment is responsible for full payment. In the case of divorce, please do not place our office into marital disputes. It is your responsibility to work out the payment of your child's medical care with the non-custodial parent.

IF WE DO PARTICIPATE WITH YOUR INSURANCE COMPANY:

All services performed in our office will be submitted as a courtesy to your insurance. All co-pays are due at the time of service. Deductibles and coinsurances are your responsibility and will be billed to you by our office. All insurance carriers have a fee schedule from which they will reimburse. However, the doctor's fee may be higher than what the insurance company reimburses or may not be a covered service. Therefore, any balances not covered by insurance become the responsibility of the patient.

IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE COMPANY:
We are not able to bill your insurance and we cannot accept payment from them for the services performed. We will provide you with an itemized statement so that you may submit the charges to your insurance company for reimbursement. Not all services provided by this office are a covered benefit in ***ALL CONTRACTS***. Payment for services ***IS DUE AT TIME OF SERVICE.*** If not paid at the time of service a **$10.00** fee will be added to the balance.

MISSED APPOINTMENTS/LATE CANCELLATIONS:
Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. We reserve the right to charge a fee for missed or cancelled appointments. Cancellations are requested 24 hours notice prior to the appointment. A **$50.00** fee will be charged for a confirmed missed appointment. After a fourth missed appointment, you will be discharged from the practice. New patient appointments (initial visit) that are missed, or not cancelled within 24 hours, will not be rescheduled and the patient will not be accepted into the practice.

FORMS AND FEES:
A **$30.00** fee is charged for the completion of FMLA forms. This form will be completed within one week.

ASSIGNMENT AND RELEASE:
I hereby authorize my insurance benefits be paid directly to Tan & Garcia Pediatrics, P.C. I understand that I am financially responsible for non-covered services. I also authorize the physician to release information required in the processing of insurance claims.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY THE OFFICE OF TAN & GARCIA PEDIATRICS, P.C. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT NOTIFICATION TO THE GUARANTOR.

Signature of Parents and/or
Responsible Parties: 1._____

2._____

Witness: _____

Date: _____

Siblings: _____

_____