STEPPING STONES PEDIATRIC AND ADOLESCENT MEDICINE

FINANCIAL POLICY

Thank you for partnering with us for your child's healthcare. We are committed to your treatment being successful. Please understand that prompt payment of your bill is considered a part of your treatment. The following is a statement of our financial policy which we request you read, agree to, and sign prior to the initiation of treatment. **PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE**

Regarding Insurance:

Our office is pleased to assist you in filing claims with your insurance company for reimbursement of these expenses. We will wait 45 days for your insurance company to pay your claim and if they do not we will offer you an additional 30 days to pay the balance.

1. The patient is responsible to pay any deductible and copayment at the time services are rendered.
2. Any portion of a billed amount that is labeled "disallowed" or "not covered" will become the patient's responsibility.
3. We will make every effort to verify your insurance benefits, however, our office NEVER guarantees that your insurance will pay for a service. If for some reason your insurance claim is denied, you are immediately responsible for any balance due.
4. We recommend that you contact your insurance carrier and become aware of your policy benefits.

Usual and Customary Rates:

Our practice is committed to providing the best treatment of our patients. We charge the rates that are usual and customary for our area. You are responsible for payment regardless of an insurance company's determination of usual and customary.

Non-Sufficient Funds/Returned Checks:

All returned checks will be assessed a $50 fee. All returned checks not paid in full within ten (10) days will be filed with the proper authorities.

Missed Appointment/Late Cancellation Fee:

There is a $50 missed appointment fee for visits not cancelled at least 24 hours prior to the scheduled appointment. This courtesy allows us to schedule another child who is in need of medical care in that time period.

Contact Information:

I agree that Stepping Stones Pediatrics and Adolescent Medicine and any affiliates may contact me by telephone or text message or automated telephone dialing system (ATDS) at any telephone number provided by me. I agree to keep this information updated.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

Acknowledgement: I have read, understand, and agree to the provisions of this financial policy.

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Patient Name **Date of Birth**

_____ _____

Signature of Parent **Date**