Pediatric & Adolescent Medicine, LLP

Financial Statement

We have direct financial relations with a limited number of insurance companies. We accept patients with most plans with Oxford, United Healthcare, Blue Cross Blue Shield and AETNA. We will bill these insurance companies directly for those patients enrolled with these plans. Please note, however, that arrangements with insurance companies are subject to change at any time. You agree to provide accurate and prompt information concerning your health insurance plan.

You agree to provide prompt notification of any changes to your insurance plan or coverage such as increased co-payment amounts, change of policy number, etc.

We MUST have your insurance information at the time of your visit in order to ensure our participation. If your insurance is a plan with which we do not participate, YOU ARE RESPONSIBLE FOR PAYMENT OF SERVICES AT THE TIME SERVICES ARE RENDERED. Upon complete payment of services, we will provide you with a detailed summary of charges to submit to your insurer for your reimbursement.

You are responsible for any co-insurance, deductible and co-payments based on your plan. If your insurance requires you to pay a co-payment, this MUST be done at the time services are rendered in order to avoid an administration fee of $25.

We will also charge a $25 administration fee to your account for all outstanding balances over sixty days to cover the costs of billing.

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 a specialist, if preauthorization is required prior to a procedure and what services are covered.

Any Well Visits appointment(s) missed or not cancelled at least 24 hours prior to appointment arrival time will incur a $50 cancellation fee. Any sick or vaccine administration appointments that are missed or not cancelled at least 24 hours in advance will incur a $25 charge. Same day appointments do not apply.

You understand that you are financially responsible for any services that are not covered by your insurance plan.

I have read the above information and understand my financial obligations.

_____ _____

Name of Patient Relationship to Patient

_____ _____ _____

Signature of Parent / Guardian Date Name of Parent / Guardian

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