BISKUP & SEGUI PEDIATRIC PARTNERS, P.C.
FINANCIAL POLICY

Thank you for choosing us as the healthcare provider for your child(ren). We are committed to providing the very best care possible. The following is our Financial Policy, which we require you to read and sign before treatment.

Your health insurance coverage is a contract between you and your insurance company to help you meet medical expenses. We are not a party to that contract. Also, we do not provide services on the basis that the insurance company will pay all charges. Insurance coverage varies greatly; therefore, it is your responsibility to contact your health plan with any questions or concerns regarding the following:

- **coverage for all services provided**
- **whether our doctors are contracted with your plan**
- **deductibles, co-payments and coinsurances**

It is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf. Understand that (regardless of any insurance status) you are responsible for the balance due on your account.

***** As a courtesy to our patients, we will file health insurance claims for primary and secondary claims but we do not accept the responsibility for settling the claim with your carrier. If payment is delayed, reduced or denied, you will be responsible for settling your balance in full with our billing department. All insurance claims that are not settled within a 60 days period will become your responsibility. This is to include any coordination of benefits information requested by your insurance company.**

We must have a current photocopy of your insurance card on file for all family members. ID cards must be presented at each visit.

Co-payments are due at each visit. Your insurance company requires payment at the time of service. If you are not prepared to pay your co-pay, we will request that you reschedule your visit.

The person who brings the child in for treatment is responsible for payment of any co-pay or balance. We will provide a receipt so that the responsible party can reimburse them. We will not bill third parties for payment of balances due.

Self Pay Patients: Full payment is due at the time of service unless an alternate financial agreement has been made with our Biller. We accept cash and personal checks.

Medicaid: Current month's Public Aid card must be presented prior to service or payment in full is expected. Your payment will be refunded upon receipt of the correct eligibility card.

Advocate Healthcare: We must have the patient's ID card in order for us to file insurance. If the patient is not on our eligibility list, you will be asked to sign a waiver accepting financial responsibility if the child does not appear on our eligibility list. No immunizations will be given if you cannot provide the child's ID card naming our doctors as PCP unless you pay at the time of service.

Account Statements: Every effort is made to avoid the cost of mailing statements. The statement will indicate any amounts due by you. Your payment in full is due upon receipt of the statement. If you feel your insurance company made an error in paying the claim, contact them immediately.

Past Due Accounts: Seriously past due accounts will be referred to a collection agency. This will result in termination of services with our office. The collection agency's fee (35%) will be added to the patient's balance. We will gladly work with you to arrange a payment plan that you can handle. Please call our Biller to set up a payment plan.

Bankruptcy: Any family filing bankruptcy must pay in full at the time of service. Any insurance payment will be refunded. Charts will be copied for transfer to another physician if you cannot comply with this policy.

Missed Appointments: Unless we receive notice of cancellation 24 hours in advance, you will be charged a minimum of $25.00. Please help us service you better by keeping scheduled appointments.

Additional Fees:
- Overdraft / NSF item paid / returned will be $25.00 plus bank fee.
- Release / copy of medical records will be $25.00 per chart per child.

If you have any questions regarding your account at any time, please contact our Biller for assistance.

I have read and agree to the terms of this financial policy. I understand that by signing this document, I am financially responsible for this account.

Name____ Date__________________

Signature of Responsible Party