FINANCIAL POLICIES, EFFECTIVE January 1, 2023

We accept Cash, Visa, MasterCard, American Express, and Discover for your convenience.

Private Pay: If you do not have insurance, payment will be due at the time of service. We require a minimum of 100% of the balance to be paid at the time of service.

Insurance: Although we are contracted with several insurance companies, it is your responsibility to make sure that our physician participates in your specific plan. If our physician is not a participating provider for your plan, you may still select our office for your medical care; "out of network" benefits will apply. It is also your responsibility to know your insurance benefits. Our office will not advise you of your insurance benefits. Please contact your insurance company at the Member Service phone number printed on your insurance card if you have questions pertaining to coverage.

As a courtesy to our patients, we will file insurance forms from our office. In order to do this, we require all information to be completed on the Patient Registration Form. We must have this information prior to your appointment. We will request an update to your information annually. Please present your insurance card at each appointment. A photo ID is required at your first visit. We make every effort to verify insurance prior to your appointments. If our office is unable to verify your insurance eligibility, you will be required to pay for your visit at the time of your appointment. If you provide the correct insurance information to our office in a timely manner, we will file a claim on your behalf. We will refund you any portion that is determined to not be your responsibility.

You are responsible for paying all co-pays at the time of service. Co-pays, co-insurance, deductible and non-covered services cannot be waived by our office, as it is a requirement placed on you by your insurance carrier. Failure to pay your portion of services rendered will be reported to your insurance company and could result in termination of your insurance plan.

Billing: If you receive an invoice from our office for a balance due, it is because that is the balance your insurance policy requires that you pay. Please contact your insurance company first if you believe there is a problem. The balance on your

invoice should be equal to the "Patient responsibility" portion of your Explanation of Benefits that you received from your insurance company plus any "non-covered services" (less any copay that was collected at the time of service). If there is a discrepancy, please call the billing office immediately to advise us. You will continue to receive invoices and be subject to collections if you do not advise us of discrepancies.

Collections: Invoices not paid within 60 days begin our collection process. Invoices not paid within 120 days are subject to patient dismissal and submission to our Collection Agency and notification to your insurance plan. Non-covered Services: The following services are considered "Non-Covered Services" by most insurance companies. The fees listed below must be paid at the time of service.

- Returned Checks: If your check is returned to us for any reason, you will be charged $30
- Forms Completion: Disability, Insurance Forms, Travel Forms, Release from Work, Prior Authorizations, and other forms are not required by all insurance plans or employers. If you require a physician to complete these forms, there will be a $10 charge in addition to your office visit charge.
- Paper Records: We will provide you, upon written request, a paper copy of your medical record. We charge a base fee of $20.00 per patient.
- Phone Visits: If you request medical services via telephone instead of a visit to our office, the following fees apply. You must be an established patient to request this service. Phone visits are done only by prior physician approval and scheduling.

WELCOME TO PEDIATRIC ASSOCIATES OF WESTFIELD. OUR STAFF AND DOCTORS LOOK FORWARD TO PROVIDING YOU WITH THE BEST OF CARE.

Patient Name (Print):_____D.O.B._____

Parent/Guardian Signature_____Date:_____

Financial Policy

I have read and understand the Financial Policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above. I understand that the terms of this Financial Policy may be amended by the practice at any time with or without notice to me.

PLEASE LIST ALL CHILDREN IN THE FAMILY

Patient's Name (s):	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Responsible Party's Name Relationship to Patient

_____ _____

Responsible Party's Signature Date

On completion, we will provide you with a copy of this policy for your records.