



Financial Policy

The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file with your insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans. **It is your responsibility at EVERY VISIT to:**
 - **Bring your insurance card and photo I.D.**
 - **Pay your Co-Payment and/or any deductibles.** Payment can be made by cash, check or credit card.
 - We accept VISA, MasterCard, American Express and Discover.
 - **Pay in full for any medical care or services that are/were not covered by your insurance plan.**
2. If your child has an insurance that we do not participate with, or your child does not have any insurance, payment in full is expected at the time of service. Your child will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients, if the charges are paid at the time of service.
3. If your insurance plan is an HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be "Private Pay" until the PCP has been changed to one of our physicians.
4. If you do not have your insurance card with you at the time of service, you will be "Private Pay" for that visit. Once you provide us with the insurance card we will submit charges and refund your payment.
5. Proof of insurance is not a guarantee of coverage or of payment.
6. **Secondary Insurance: We do not file secondary insurance.** You may request a copy of the claim to file yourself.
7. **We do not accept Medicaid.**
8. **You are financially responsible for any amount not covered by your child's health insurance plan.**
9. **You are financially responsible for all charges incurred in your child's care and treatment.**
10. If you have questions about your insurance, we can help where possible. However, specific coverage issues should be directed to your insurance company members services department. The telephone number is usually located on your insurance card. In the event that payment is erroneously denied by the insurance carrier, it is your responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier.
11. **If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency.** Accounts are considered past due after 90 days. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
12. To protect your child's records, we ask you to provide our office with a driver's license or other picture ID. Annually, or as changes occur, we will ask you to sign our financial policy and update your registration information. We will scan your insurance card and ID into your child's electronic medical chart. We will check these documents prior to releasing your child's records.
13. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit.
14. Payments will be requested by and returned to **Lala Associates, PA** as Sprout Pediatrics does business under this association.

Late Arrival/No Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule to another day or may be worked back in to the schedule/moved to the end of the day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge your child from the practice. **Appointments that are missed or not cancelled prior to the scheduled appointment time (minimum 1hr prior for same day sick appts and minimum 24hr prior for well check appts) will be charged a No Show fee of \$50.00. Future appointments can NOT be scheduled until this fee is paid.**

ADVANCED BENEFICIARY NOTICE

These services may NOT be covered by your insurance carrier. The purpose of this list is to help you make an informed choice about whether or not you choose for your child to receive certain services. The fact that your insurance carrier does not cover a service does not mean that you should not receive that service, it just means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance carrier, you will be financially responsible for the balance on your account.



SERVICE

Pure Tone Screening Auditory Test (hearing test)
Screening of visual test acuity (vision test)
Developmental Testing
Preventive Medicine Risk Management
(counseling for delayed vaccine schedule)

CPT Code

92551
99173
96110
99401/99402

Additional Fees – See Office Policies for additional details

- After hours call triaged to nurse line - \$15 per call
- Forms not completed at time of visit - \$10 if simple/signature only, \$25 if more complex (ie Asthma action, allergy action, extensive camp packets, college forms etc). Additional \$25 rush fee if needed in less than 72 hours
- Collections Fee – 30% of the amount due if your account is sent to collections
- Medical Records not released to another physician - \$25 and up per chart for printed copies, \$10 for electronic copies

We will not provide medical care to children whose Parents/Guarantors refuse to sign and comply with our financial policy.
Signature of Understanding: I have read and understand the above stated financial policy.

Child's Name Date of Birth Child's Name Date of Birth

Child's Name Date of Birth Child's Name Date of Birth

Patient or Parent/Guardian if Patient is under 18 years of age Date

ASSIGNMENT OF BENEFITS

I, the undersigned authorize payment of medical benefits to Sprout Pediatrics for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

Patient (if 18 or older) Parent/Guardian (if Patient is under 18 years of age) Date