DAVENPORT PEDIATRICS

CREDIT AND FINANCIAL POLICY

INSURANCE INFORMATION

PRIMARY INSURANCE: ____ PHONE NUMBER: (_____) _____-__________

ADDRESS OF INSURANCE COMPANY: ____

NAME OF POLICYHOLDER: ____ RELATIONSHIP TO PATIENT:__________________________

POLICY ID #: ____ GROUP #: ____

POLICYHOLDER SOCIAL SECURITY #: _____________________________________ POLICYHOLDER DATE OF BIRTH: ____/____/_________
MM DD YYYY

If the Patient has siblings (brothers or sisters) who have the <u>same insurance policy</u>:

NAME OF CHILD:____ DATE OF BIRTH: _______/_______/__________
MM DD YYYY

NAME OF CHILD:____ DATE OF BIRTH: _______/_______/__________
MM DD YYYY

NAME OF CHILD:____ DATE OF BIRTH: _______/_______/__________
MM DD YYYY

CREDIT AND FINANCIAL POLICY

Davenport Pediatrics, P.A. wishes to notify you of its policies regarding the financial responsibilities associated with services rendered to you or to a member of your household/family.

Insurance

Co-payments are due and payable at the time of visit. As a courtesy to you, we will bill your insurance company provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct information, the charges will transfer to your responsibility. You are financially responsible for charges deemed by the insurance company to be billable to the patient. You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

You shall also be responsible for any claim denied by the insurance company. The insurance company may deny a claim for any of the following reasons:

(1) Davenport Pediatrics is an out-of-network provider or Davenport Pediatrics does not participate with your insurance company.
(2) The claim is rejected because there was no insurance coverage at the time of service.
(3) Davenport Pediatrics was not the assigned primary care physician for the patient or for your insurance company.
(4) The procedure/ lab work done is not a covered service or benefit by your insurance company.
(5) Your insurance company is still waiting for additional information that they have requested from the parent/ guardian of the patient.
(6) Your insurance company has already made the payment and the remaining balance is your responsibility.
(7) Only hospital charges are covered by your insurance company.

There may be other reasons that the insurance company may reject a claim filed on your behalf. If there are any questions regarding their decision(s), you must contact your insurance company immediately.

Cash Account

If proof of insurance is not provided, your account will be considered a cash account and payment in full of all charges will be required at the time of service.

At this time, even if you are able to subsequently provide verifiable insurance information, and the time frame for billing the insurance has not expired (generally 45 days), we will **<u>not</u>** be able to bill the charges to your insurance company for you.

Billing

The billing statement you receive will show patient balances due, in addition to insurance company payments and pending amounts. Patient balances are due from you upon receipt of the statement.

Appointments

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hour notice, consider that another child could have been seen at that time. We reserve the right to charge a $25 cancellation or 'no show' fee. In order to see each patient on time, your appointment may need to be rescheduled if you arrive 10 minutes or more late.

Returned Checks

You would also be responsible for the $35 returned check fee that the bank would charge in the event that the personal check issued by you is returned to us for any reason. You must also consult with your financial institution for any other fees they might charge you.

ASSIGNMENT OF HEALTH INSURANCE BENEFITS

I hereby authorize DAVENPORT PEDIATRICS, P.A. to collect on my behalf any insurance/ medical benefits payable to me for the service(s) they have provided and assign to them the payment thereof. I authorize and assign the payment of any insurance/ medical benefits applicable to the service(s) cited on the claim form to DAVENPORT PEDIATRICS, P.A. This assignment will remain in effect until revoked by me in writing. A photocopy of this form is considered as valid and effective as the original.

I understand that this assignment does not relieve me of any responsibility I may have for any payment of charges that are not covered by the insurance company. I understand that I may be held responsible for any or all unpaid charges on this account.

I have read and understand the financial policy of DAVENPORT PEDIATRICS, P.A. and I agree to be bound by its terms I also understand and agree that such terms may be amended by DAVENPORT PEDIATRICS, P.A. at any time.

PRINTED NAME OF PARENT/ GUARDIAN: ____

SIGNATURE OF PARENT/ GUARDIAN: ____ **DATE:** ___________________
MM / DD / YYYY