Mount Pleasant Pediatrics, PA - Financial Policy

1. **IF YOU FAIL TO UPDATE YOUR INSURANCE INFORMATION, AND YOUR INSURANCE DENIES A CLAIM YOU WILL BE RESPONSIBLE FOR THE TOTAL CHARGES.**

2. I understand TEFRA Medicaid is the Only secondary insurance Mount Pleasant Pediatrics files.

3. Co-Pays and deductibles are required at the time of your visit. If your co-pay is not collected at the time of service you will be charges a service fee of $5.00.

4. **Forms of payment:** we accept cash, check, money orders, Visa and MasterCard.

5. Referrals: In the event referral for testing or subspecialty care is necessary, it is the patient's responsibility to have the referral in place at the time of service. We are unable to process referrals for testing or subspecialty care without 24-48 hour notice.

6. Insurance Assignment: If this office participates with your insurance network we will take the appropriate adjustments. If your policy does not cover a charge, you will be responsible for the charges. **IT IS YOUR RESPONSIBILITY TO FOLLOW UP WITH YOUR INSURANCE COMPANY WHEN CLAIMS ARE DENIED.** We file your primary insurance on your behalf. However, filing secondary insurance is the responsibility of the patient or guardian.

7.Self pay patients: If you have no insurance, and remit payment at the time of service, a 20% adjustment is taken from the total due. This does not apply to payment plans, patients with HSA, MSA or high deductible insurance coverage.

8. HSA, MSA and high deductible insurance holders: With the exception of Insurance-covered Well Child Visits, you are responsible for full payment for all visits at the time of service. We will accept your check or credit card on the HSA or MSA account.

9. There is a $32.00 charge for **returned checks**: Our bank charges us a fee if your check is returned. All returned checks must be picked up within two weeks. If not, your account will be placed with our collection agency.

10. I understand that **I am financially responsible for all charges not covered by my insurance.** I understand that my insurance coverage may not cover all my medical charges and that **I will be fully responsible for co-pays, deductible,co-insurance, and services not covered**.

By initialing you are agreeing to the terms of our financial policy. **Initial _____ Date_____**

PATIENT OR AUTHORIZED PERSON SIGNATURE: I authorize the release of any medical or other information necessary to process claims. I also request that payment of government benefits be made to the party who accepts assignment. I authorize payment of medical benefits to the undersigned physician or supplier for services rendered. I acknowledge receipt of a copy of the Privacy Notice of Mount Pleasant Pediatrics.

_____

Child's Doctor

Signature (PLEASE PRINT)

Mount Pleasant Pediatrics

Today's Date_____

Dr._____

Last/Family Name_____

Children's **LEGAL** Names	Nickname	**Social Security #**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please Circle Preferred Phone Number

Address_____ Home Phone_____

City_____State_____Zip_____

Father's Name_____Cell_____

Father's Place of Employment_____ Work # _____

Father's DOB _____Father's SSN_____

Mother's Name_____ Cell _____

Mother's Place of Employment_____ Work # _____

Mother's DOB _____Mother's SSN_____

Parents: Married _____ Divorced _____ Separated _____ Single _____

If Separated/Divorced:

Guarantor's Name & Address:

_____

City: _____ State: _____ Zip: _____

Emergency Contact: _____ Phone: _____

E-Mail Address: _____ (for billing purposes only)

Family History (state relationship)

Heart Disease_____	Diabetes _____
Kidney Disease _____	Seizures _____
Allergies/Asthma _____	Eye Disease _____
Bleeding Disorders _____	Cystic Fibrosis _____
Hypertension _____	Anemia/SS Disease _____
Infant Deaths _____	Birth Defects _____
Cancer _____	Other_____