PAYMENT POLICIES

Patient Name: _____ **DOB:** _____
Patient Name: _____ **DOB:** _____
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Thank you for choosing us as your pediatric primary care provider. We are committed to providing your child with quality healthcare. Because some of our patients have had questions regarding patient and insurance financial responsibility for services rendered, we have developed this payment policy. Please feel free to ask us any questions you may have.

INSURANCE: We participate with most insurance plans including Medicaid. If you are not insured by a plan with which we participate, payment in full is required at each visit. If you *are* insured by a plan with which we participate, but do not have an up-to-date insurance card, payment in full is required at each visit until we can verify your coverage. *Knowing your insurance benefits is your responsibility*. Please contact your insurance company with any questions you may have regarding your coverage provisions.
PROOF OF INSURANCE: All patients must provide proof of insurance at the time of service. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of a claim.
CO-PAYMENTS: All co-payments are due at the time of service via cash, check, or credit card. In the event a personal check is returned or unpaid from your bank, your account will be charged with a returned check fee of $40.
DEDUCTIBLES: If your insurance plan is subject to routine deductibles and co-insurance, we require you to keep a **CREDIT CARD ON FILE** so we can collect those charges as soon as your insurance carrier assigns the appropriate amount of patient responsibility.
RETURN CHECK FEE: A $40.00 fee will be assessed to your account for any returned checks.
NEWBORNS: Newborns are covered for the first 30 days by the mother's insurance policy. You should contact your insurance company as soon as possible to add the new child to your policy. You must have your child added to your policy by the one month well visit and should have an insurance card to present at that visit.
NON-COVERED SERVICES: Please be aware that your insurance company may not cover some of the services your child receives at their visit with us. The providers at Litchfield County Pediatrics follow nationally recognized standards for well and sick care. If a service is provided to your child but not covered by your insurance, you will be responsible for the resulting charge.
INSURANCE COVERAGE OF WELL VISIT SCREENING TESTS: In general, well visit charges are covered by most insurance companies. However, the cost of screening tests done during a well visit may or may not be covered. During your child's well visit, your provider will perform a variety of health screenings that are recommended by the American Academy of Pediatrics Bright Futures Guidelines and are considered standard of care in pediatrics. Some insurance companies cover these screenings fully, some "bundle" the cost, some push the cost to the deductible, and others do not cover the cost of the

screening tests at all. As a result, you may have responsibility for some of the well visit charges. Here are some examples of well visit screening tests that are done in our office:

Screening tests include (but are not limited to) the following:
Edinburgh Post-Partum Screening
Ages and Stages Questionnaire (developmental screening)
MCHAT (autism screening)
PSC-17 and PHQ-9 (mental health screening questionnaires)
Hemoglobin (anemia screen)
Lead poisoning screen
Vision screening: Photo-screening (infants, toddlers, young children)
Vision screening: Vision chart (older children and teens)
Hearing screening
TB screening questionnaire and if positive, PPD placement
Brenner FIT questionnaire, Transition readiness questionnaire, and others depending on risk

INSURANCE COVERAGE OF WELL VISITS *PLUS* PROBLEM-BASED VISITS: Well visits may uncover new problems, issues, or illnesses that require additional evaluation or management beyond the typical well visit (ex. ear infections, new onset asthma, anxiety/depression, other new concerns). In addition, if your child has very complex chronic health care needs, your provider may spend a significant amount of extra time addressing those issues beyond what is typical for a routine well visit. In these situations, your insurance may be charged a problem-based office visit in addition to the well visit. While well visits may not require a co-pay/deductible, problem-based visits typically do require a co-pay/deductible payment and, as a result, you will be responsible for that charge.

NONPAYMENT: All statements are due upon receipt. If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise discussed. Please be aware that if a balance remains unpaid, we may need to refer your account to a collection agency, and you and your immediate family members may be discharged from our practice. Should this occur, you will be notified by mail that you will have 30 days to find alternative medical care. During that 30-day period, our providers will only be able to treat you for ongoing and emergency care.

MISSED APPOINTMENTS/LATE CANCELLATIONS: We reserve the right to charge for missed appointments and for canceled appointments if the cancellation is not made prior to the day of the scheduled visit. These charges will be your responsibility and will be billed directly to you. Please help us to serve you better by keeping your scheduled appointment or by canceling prior to the day of the scheduled visit. An excessive number of missed appointments will result in discharge from the practice.

RECORD COPYING FEE: If you transfer out of our practice, we will provide you or your new provider a copy of your records free of charge. Any subsequent requests, legal requests, or requests from the State of Connecticut disability program will be charged at a rate of 65 cents a page.

Thank you for your understanding of our payment policy. Please let us know if you have any questions or concerns.

_____ _____ _____

Parent/Guardian Name **Parent/Guardian Signature** **Date**