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Financial Policy

Our office is committed to providing optimal care to our patients and their families. We have developed this policy to serve as a clear understanding of your financial obligations and to follow terms set forth in insurance contracts.

INSURANCE CARDS: Please bring your child's **current** insurance card with you to each visit. This helps ensure that the proper information is processed, and the appropriate insurance is billed for that day's visit. If your insurance changes, it is your responsibility to update information as necessary.

CO-PAYS: If your insurance requires a co-pay, it must be paid at each visit. The co-pay must be paid by the person who brings the child in for the visit, via phone prior to visit, or via patient portal. A late fee of \$20.00 will be added to any co-pay that is not paid on the day of service.

DEDUCTIBLES: If your insurance plan has a "deductible", **this amount is your financial responsibility.** This is the amount you must pay out of pocket before your insurance company will start to pay benefits. It is a contract between you and your insurance company. Deductible balances must be paid within 30 days per office policy.

WAIVER OF NON-COVERED SERVICES: All insurance plans are different. Some plans do not cover standard of care screenings such as vision, hearing, objective developmental screenings, etc. When this occurs, the charges may become patient financial responsibility.

PAYMENT TERMS:

1. Payment of co-pays **AND** outstanding balance is required at each visit.
2. Outstanding balance must be paid within 30 days.
3. Any balance over 30 days will be considered delinquent
4. **Easy-Pay:** We offer a convenient option to keep a credit card on file (info stored securely, we will not have access to your card number)
5. Payment plans can be set up to avoid collections only if balance is less than 30 days past due. Contact billing for details.

RETURNED CHECK FEE: There will be a \$35.00 fee for a returned check. In addition, all future payments will need to be made with either cash or credit card.

NEWBORNS: Insurance companies generally allow only *30 days* to add your newborn to your insurance plan. Please call ASAP to get this done. Once you receive your child's card, please provide us with a copy. If you fail to add the baby to the plan, you will be financially responsible for any visits.

DIVORCE SITUATIONS/SEPARATE HOUSEHOLDS: We cannot be involved in the financial arrangements determined by your divorce decree. We will only bill the parent who is listed as financially responsible.

NIGHT NURSE TRIAGE: Our office provides an *after-hours* **EMERGENCY** triage service (4:30pm-8:00am) for cases where a parent or caregiver needs to speak with a registered nurse for medical advice. There is a charge of **\$25.00** for this service that is **NOT COVERED** by insurance. This will be billed directly to you. **Many health insurance companies have their own nurse advice line. Please check the back of your insurance card/policy for details.*

*** For all other **ROUTINE** calls such as medication refills, dosing questions, etc. please call during our regularly scheduled hours.

Effective 12/01/2023

LETTERS AND FORMS: There is a charge for all forms not requested at a regular well child visit. The charges are as follows:

1. **HEALTH FORMS:** \$10.00
2. **SAME DAY HEALTH FORM:** \$15.00 (If we are able to accommodate)
3. **FMLA/Physician Letters:** \$50.00 (May require a separate office visit)

ONE school/sports form will be provided per year, given at the well child visit, at no charge. The school/sports/camp/daycare form will be saved to your child's chart and you will have access to it via our patient portal. We will not send or fax these to the school, nor will we send immunization records. All are available in the patient portal. You can forward them to the school at your convenience.

MISSED APPOINTMENTS/LATE CANCEL/LATE ARRIVALS: For appointments cancelled with less than 24 hours notice a \$50.00 fee will apply. If you are more than 15 minutes late to your appointment, we consider this a missed appointment and the fee will also apply. This fee must be paid in full before your appointment will be rescheduled. If you have 3 missed appointments it may result in dismissal from the practice.

REMINDER NOTIFICATIONS: It is your responsibility to remember your scheduled appointment day and time. As a courtesy, we offer appointment reminders. However, there may be situations in which you may not receive a text, email, or call due to unforeseen circumstances. In this case you are still expected to maintain your appointment, otherwise a fee will be applied to your account. It is your responsibility to update/notify the staff as to your preferred method of communication.

TRANSFERRING MEDICAL RECORDS: A legal guardian must sign the record release. By law our office has 30 days to complete the transfer to your new health care provider or provide the records directly to you. Only pertinent records will be transferred such as immunization records, growth charts, most recent labs, specialist notes and recent illnesses. Should you need the entire medical record a charge of \$0.68 per page, plus postage will apply.

SICK COMPLAINTS DURING WELL VISITS: Insurance companies require us to file all services offered at a visit. Well child care and sick child care are separate codes for the insurance. We may complete visits at the same time for your convenience if time allows, but at times this may result in a co-pays and deductibles just as it would if it were billed on a separate day.

SELF PAY POLICY: If you have **NO INSURANCE**, we require a \$125.00 deposit (sick visits) and \$175.00 (well visits), prior to your child(ren) being seen. We offer a 20% discount if visit is paid **IN FULL** on the day of the service. The discount will be applied at check-out and the deposit will be applied to your balance. Any remaining balance must be paid after the visit at check-out. ***Discounts are not applied to vaccines***

I have read and agree to the terms of this financial policy. I will be provided a copy for my records at my request.

Signature of Parent /Guardian/Patient

Date

Printed Name

Children's Names & Dates of Birth:
