



Pediatric Partners of Virginia Financial Policy

Pediatric Partners of Virginia is dedicated to providing excellent care and understanding overall service to every patient at every visit. In the interest of avoiding misunderstandings that may arise due to any financial matters, please take note of our financial policy and sign below if you are agreeing to be bound by these terms:

Our office participates in most major health plans, but please remember:

- It is your responsibility to verify that the pediatrician is a participating health care provider in your health plan. This should be done prior to making an appointment.
- Identification and the patient's insurance card must be brought to each visit so that we can ensure that we are billing the most current insurance plan.
- The insurance policy holder's/grantor's date of birth and social security number are required for account verification.
- It is your responsibility to know your benefits and to understand that if services rendered are applied to your deductible or considered non-covered services, you will be responsible for payment.
- Co-pays are due at the time of service.
- Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of an insurance claim. You are responsible for communication with your carrier regarding denied claims.
- Self-Pay patients are required to pay for the service in full at the time of visit.
- A \$10.00 fee will be charged for the completion of each form that is not requested during the preventative check.
- A medical records fee may apply for records requests and will be priced at allowed state rates.
- Courtesy Appointment reminder calls are made to confirm appointments. It is your responsibility to keep account information up to date. A 24-hour notice is required if you need to cancel an appointment. If sufficient notice is not provided, you could be considered a "no show" and a \$50.00 "No Show Fee" or a \$25.00 "Rescheduling Fee" will be applied.
- All balances are due within 30-days of the first statement. **Please contact our Billing Office at 804-323-9100** if you have any concerns regarding your bill so we can assist you. If a payment is not received in full within 60 days a \$10.00 late fee will be charged.
- Delinquent accounts more than 90 days past due, with no payments and/or broken payment arrangements are subject to collection activity. You will be notified by phone or in writing prior to collections.
- In the unfortunate event that we need to assign an account to a collection agency, an additional fee of 40% will be added to the delinquent balance on the account. Any discounts will be added back to the balance and the amount sent to the collection agency will be the full fee.
- Existing patients with delinquent accounts, accounts turned to a collection agency, active bankruptcy claims or have balances written off to bad debt **may not be seen at a Pediatric Partners of Virginia office until such debt is satisfied or a payment arrangement is in place.**
- Returned checks will be assessed a \$50.00 returned check fee and we retain the right to refuse payment by check for future appointments.
- Repeat violators of these policies could be dismissed from our practice.

Should you receive a bill from us, and you find yourself in a financial bind, PLEASE call us to discuss setting up a payment plan. If more charges are added to the balance, new payment arrangements will need to be made. We are happy to help and are here to assist you.

By signing this form, I acknowledge that I have read, understood and agree to pay for all services rendered in accordance with the terms set forth in the financial policy of Pediatric Partners of Virginia.

Children's Names and DOBs: _____

Signature of Guarantor

Printed Name

Date