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Carolina Pediatric Surgery Patient Financial Policy

Thank you for choosing Carolina Pediatric Surgery as your health care provider. We are committed to providing you the best quality medical care. As a part of this relationship, we wish to establish our expectation of your financial responsibility. The following is a statement of our Financial Policy:

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE.

We accept: Cash, Checks and Credit Cards

INSURANCE:

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier.
- Know your benefit coverage, as well as your dependents, prior to receiving services.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission requirements set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.
All co-pays and deductibles are due at time of treatment. If your insurance carrier considers us “out of network” or does not participate with us, you are responsible for payment in full at the time of service.

To summarize, your financial responsibility may include:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pended claims due to lack of patient and/or guarantor information
- Non-Insurance and/or out-of-network benefits

If you fail to receive an Explanation of Benefits (EOB) from your plan within 45 days of treatment, we suggest you contact your insurance plan, as they may not have made payment. Payment not received in 60 days from the date of service, may be transitioned to patient responsibility and you may be required to make other payment arrangements.

SELF PAY:

If you do not have insurance, you will be considered a “self-pay” patient. “Self-pay” patients will be given an estimate of what will be due before the visit. **Payment is required in full at the end of your visit. Self Pay Patients are required to fill the credit card on file form prior to the visit.**

INITIAL HERE:_____

CO-PAYMENTS:

Payment is expected at time of service. Failure to produce payment at check-in may result in your appointment being rescheduled.

INITIAL HERE:_____

DIVORCE DECREES/RULINGS:

In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. This office is not a party to your divorce decree. We will not bill another individual or estranged spouse for payment. Copayment is due at the time services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent's responsibility to collect form the other parent. Carolina Pediatric Surgery will not act as a mediator in this effort.

INITIAL HERE:_____

SAME DAY CANCELLATIONS OR MISSED APPOINTMENTS:

Unless canceled at least 24 hours in advance, our policy is to charge **$35.00** for missed appointments. We cannot file nor will insurance plans pay for this charge. Please help us serve you better by keeping, or canceling your appointment in advance.

INITIAL HERE:_____

RETURNED CHECKS:

Any returned checks will be charged an additional **$25.00** fee to be added to your account balance. This is in addition to any charges charged by your institution.

INITIAL HERE: _____

Testing (Laboratory Tests, Imaging, and Other Investigations):

I understand that an outside laboratory, radiology department or other facilities will be used for investigations. These facilities may process blood, urine or tissue specimens as ordered by the physician. These services will be billed separately by respective facilities. It is my responsibility to contact the lab or these facilities with any questions regarding the cost of the investigations, or if I have any questions regarding their bill.

INITIAL HERE: _____

COLLECTIONS:

Any past due balance not paid will be turned over to our outside collection agency after 90 days. In the event that the bill remains unpaid and litigation ensues for collection of sums due, this office shall be entitled to reasonable attorney fees and court costs. After 90 days, any unpaid balance will be sent to an outside collections agency and patient will be responsible for any fees accrued.

INITIAL HERE:_____

CREDIT CARD ON FILE POLICY:

We require all families to leave a credit card on file to be charged for all patient responsible balances that are greater than 90 days old.

INITIAL HERE: _____

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

I have read and agree to this Financial Policy:

Signature of Patient or Responsible Party:_____ Child's Name and Date of Birth:_____