Office / Financial Policy Agreement

1. **Payment is required at the time of services rendered** unless other arrangements have been made in advance. This includes applicable deductible amounts, co-insurance and co-payments for participating insurance companies. **Co-payments for children are due at time of service regardless of who brings the child in.** Please make arrangements to send payment with the person bringing your child in. You are required to pay your co-payment before your visit. We accept Visa/MC/Cash.
2. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25 charge for returned checks. If not paid within 60 days, Somers Pediatrics will begin various collection activities including but not limited by submitting the past account to collections.
3. **Self Payment (Private, Cash Payment):** if you have no insurance coverage. **We do not retro bill for self pay visit even though you get insurance with retroactive dates.** However, we will gladly provide with a copy of super bills and your receipt.
4. Please have your driver's license, shot record and insurance card ready at check-in. If you do not have a valid insurance card, we will hold you responsible for the full amount of the visit. We ask that you please contact our office with any address, telephone, or insurance changes.
5. **Missed/Sibling Appointments:** Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. Excessive abuse of scheduled appointments may result in discharge from the practice. As a courtesy to all our patients, you may be asked to reschedule your appointment if you are more than 10 minutes late. For check up appointments and sick visits, siblings are scheduled in consecutive time slots. ***We ask that you do not bring in a sick sibling who does not have an appointment with a child who has a scheduled appointment as this causes the physician to get behind on their scheduled appointments.*** If you wish to have a sibling seen, you will be given the next available appointment and must wait to be seen. ***All patient's must have an appointment to be seen.***
6. **Automobile accident patients:** We DO NOT treat automobile accident patients. Therefore, require payment at the time of service. We will not accept a letter of protection from an attorney as a guarantee of payment or third party insurance payments.
7. **Children of divorced parents:** Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgement must be determined between the individuals involved, without the inclusion of Somers Pediatrics.
8. Your insurance company may require additional information to process your claim such as accident details, coordination of benefits or student status. Your insurance company will request this information in writing. It is very important that you provide your insurance company with the information to process your claims. You are allowed 10 days to get this information to your insurance company. If, after 10 days, your insurance company has not received this information from you, the balance will become your responsibility and you will receive a statement from us for payment in full.
9. **Secondary Insurance:** The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. Patient agrees to provide such information as outlined below. Patient agrees to notify provider in the future immediately of any additions changes or deletions in primary or secondary insurance coverage.

Initial/complete as applicable.

_____My child has NO secondary insurance coverage

_____My child has secondary insurance coverage as described on the attached demographics form.

10. We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance it is your responsibility to contact our office at (903)230-3311 within 30 days of receipt of the initial statement.
11. Patients who have not made a payment on their account in the past 30 days will be required to pay before they are seen in the office again, except in the case of an emergency. We realize that people experience financial difficulty from time to time. Please contact our office if you are unable to pay your payment, and we will make every effort to extend reasonable arrangements to you until the account is resolved.
12. After your insurance carrier has paid their portion, there may be an amount not covered and a balance due. We will send you a statement. The balance is due upon receipt of statement.
13. If your insurance company mistakenly send you our payment, please forward the check immediately. Failure to do so may result in your account being turned over to a collection agency or small claims court.
14. **Prescription refill:** Please contact your pharmacy to put in a refill request. Please allow 3 business days for all prescription refills to be completed. If you lose a prescription or shot record there will be a $5.00 fee for a new one. Please have your Pharmacy name, number and location to send your prescription to the correct pharmacy. It is your responsibility to UPDATE us with any pharmacy changes.
15. There is a $5.00 charge for head start forms and $25.00 for FMLA forms that need to be filled out we require 3-5 business days for completion.
16. Please confirm with your primary health insurance that we are in network. In case we do not accept your insurance or we are not the PCP, the patient will be responsible for the bill. Payment will be due at the time of visit.
17. Medical records transferred to patients and/or guardians will be charged a $25.00 fee for the first 20 pages then after that each page will be $0.50.
18. We may charge you a $25.00 "No Show" fee if you fail to cancel or reschedule your appointment at least 24 hours prior to your appointment date
19. **After Hours** In case of an emergency call 911. For non-urgent medical advice, contact your insurance company's nurse advice line. This number can be found on the back of your insurance card. If your insurance nurse line was not able to give you reassurance or unable to reach them, if still in need of medical advice, please call Somers Pediatrics office for after-hours instructions. **Please be aware there may be a fee.**

I, _____, do hereby affirm that I have read and understand the above policies. I hereby assign Somers Pediatrics all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier to issue payment directly to my treating physician for medical services rendered to me or my dependents regardless of my insurance benefits, if any. I authorize Somers Pediatrics to release medical information that may be necessary to request reimbursement from insurance companies to whom they have submitted a claim. I give permission for Somers Pediatrics to treat and provide services needed to the patient understand that I am responsible for all medical fees during my treatment with Somers Pediatrics. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Signature of Parent or Guardian Date