Financial Policy

Your insurance is a contract between you and the insurance company. We are not a party to that contract. Not all services are a covered benefit. We must emphasize that as a medical care provider, our relationship is with you and your child, not your insurance company. While the filing of an insurance claim is a courtesy that we may extend to our patients, all charges are your responsibility from the date the services are rendered.

We will be happy to bill your insurance and will accept the assignment; however, any unmet deductible, coinsurance and copay will be collected at the time service is rendered. Any difference will be included in our monthly statements and payments are expected upon receipt.

If there is an uncertainty regarding insurance coverage for services that we provided, we prefer that you contact your insurance carrier directly for benefits on your plan.

If APC Pediatrics is a participating provider for your insurance company and your policy requires a written referral for any visit to the specialist you are responsible for obtaining this referral, by informing us at least 36 hours in advance to the appointment time, in order for us to obtain the referral to consult the specialist, otherwise you might be responsible for the insurance denial of services provided by the specialist.

Payment for service is due at the time services are rendered. Any patient responsibility transferred by your insurance is due immediately after is determined by your insurance and communicated by us through our monthly statements. For your convenience, we offer the following methods of payments: personal checks in person or by mail and credit card payments either in person or by phone.

There will be a fee of $20.00 to the patient's account for missed appointments that were confirmed with the patients' parents or appointments canceled without at least 8 hour advance notice.

FINANCIAL ARRANGEMENTS

We expect payment in full at each appointment. All returned checks are subject to an additional $25 fee.

AUTHORIZE AND RELEASE

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits.
I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf my dependents. I understand and accept that I am financially responsible for any and all charges incurred for professional services rendered to me. I also understand and accept that I am responsible for any charges incurred should collection proceedings become necessary to enforce this agreement.
I have read and understood the above.

Patients Name _____ Date _____

X_____ Witness_____

Signature of the parents