Mountain View Pediatrics

OFFICE FINANCIAL POLICY

We are committed to providing your children with the best care possible. The goal is best achieved if everyone is aware of our financial policy. Clear understanding of our financial policy will be an integral part of our professional relationship.

Insurance plans vary considerably, and we cannot guarantee or predict what part of our services will or will not be covered. It is important for you to be an informed consumer who understands the specifications and/or limitations outlined in your benefit plan. If you are unsure of your coverage and/or specific benefits, please contact your health plan directly to discuss your plan details.

For patients with no verifiable proof of insurance *or are uninsured*, payment in full is required from whoever accompanies the patient, whether parent, guardian or relative.

IF WE *ARE CONTRACTED* WITH YOUR INSURANCE COMPANY

Initial on each line item required

1. All services performed by our physician while in-patient at the hospital will be submitted as a courtesy to you. You are responsible for contacting your health plan to determine whether or not authorization or pre-certification criteria is required and met. (_____)
2. Encounter services in office, whether rendered by a physician and/or medical staff, we are required by insurance contracts to collect all co-pays, co-insurances and/or deductible portions. This contractual obligation is placed upon our practice in order to remain a participating provider by health insurance companies. (_____)
3. ENCOUNTERS BY MEDICAL STAFF/NURSE ONLY APPOINTMENTS: For this particular encounter with our medical staff, we will submit a claim for all services provided, based on the benefits you hold through your health plan, we will allow the processing of the claim prior to requesting payment. We will notify you of any balance due after the claim is processed. (_____)
4. ENCOUNTERS FOR PREVENTATIVE CARE-WELL CHILD CHECK-UPS: Our physician will render services outlined and recommended by the American Academy of Pediatrics. Services requested and/or discussed during the well child check-up and fall outside of your preventative benefits, will be charged and submitted to your health plan. We will allow your insurance company to process these services based on the benefits you carry. (_____)
5. Once your health plan(s) process our service claim, all additional balances turned over as patient responsible are to be paid within 30 days of remit received. (_____)

IF WE ARE *NOT CONTRACTED* WITH YOUR INSURANCE COMPANY

Full payment is required the day the services are rendered. We will be happy to submit a onetime courtesy claim on your behalf, or provide you with a detailed receipt to submit all service charges to the health plan on your own. Not all services provided by an out of area or non-contracted provider will be covered. We recommend you contact your health plan directly to verify the status of our physicians within your network and/or health plan.

THE FINANCIAL AGREEMENT

We must emphasize that as pediatric providers, our relationship is with you and our patient, not your insurance company. While the filing of a claim is a courtesy we extend to our patients and families, all charges, plan benefits and network standing are strictly your responsibility from the date services are rendered. Our Physicians and staff are not responsible for verification and /or clarification of your benefits. All information provided by our staff is not a guarantee of benefits, coverage or payment by your health plan. Reconciling balances as a result of, but not limited to, unresolved coordination of benefits, required updates and/or with holding any other insurance information from our office is the guarantor's responsibility.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY MOUNTAIN VIEW PEDIATRICS. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION.

Signature of Parent or Guardian:_____

Print Name of Parent or Guardian_____

Signature Date: _____ Witnessed By: _____

Patient Name: _____

Siblings:_____