

Stepping Stones Pediatrics, PLLC

Financial Policies

Thank you for choosing Stepping Stones Pediatrics. We are committed to providing outstanding patient care to children and adolescents. Before we provide medical services, we require that you review our financial policies and agree in writing to accept them.

1. Payment is required at the time of service. This policy applies to applicable and estimated co-insurance and co-payments under your health insurance policy, provided we are in network with your plan. If we are not a participating provider, you are responsible for paying the out-of-network rates at the time of service. We will file your insurance if our office participates with your individual insurance plan. If you do not have health insurance, payment is due in full at the time of service.

We accept cash, personal checks, Visa, MasterCard, and Discover. We do not accept post-dated checks. There is a \$25 charge for returned checks.

2. Our office participates with many health insurance plans. Because each plan is different, we may not have all the details of your insurance benefits. Some of your questions may be best answered by a representative of your insurance company.

3. We must have a copy of your insurance card to file insurance for the patient. You must be able to present your insurance card at every visit. If we do not have current insurance information, we automatically consider the patient to be self-pay. After we have accurate information on your insurance eligibility and coverage, we will file a claim with your insurance company.

4. All insurance changes must be given to us at the time of service. If your insurance changes and we are not notified, you will be responsible for all charges and we will be unable to bill your insurance for any prior charges before the change notification.

5. In the event that your health insurance plan determines a service to be “not covered” you will be responsible for this charge.

6. All charges, not paid at the time of service, for services incurred with our office, will become due and payable 30 days from the date of service. This will allow sufficient time to process insurance and to make payment in full of any balance remaining applicable to deductibles or co-insurance amounts. If we have not received payment from the insurance company, the total balance due becomes your responsibility.

7. For those patients who are members of a HMO, PPO insurance plan such as Cigna Healthsource, PCP, etc., please verify with the Front Office staff before your visit that you do have a current authorization to be seen. If you have no authorization you will be responsible for the visit charges today.

8. The responsibility for payment for services rendered to any dependent children whose parents are divorced rests with the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of our office.

9. Any supplies that you receive from our office must be paid for in full at the time of service. Insurance companies do not cover miscellaneous supplies so these costs are the patient's responsibility.

10. This office does not perform third party billing. In the event of an accident, etc., the patient is responsible for all charges incurred at the Practice and, in turn, responsible for filing their own insurance with the third party.

11. Patients with an outstanding balance of more than sixty (60) days old, must make arrangements for payment prior to scheduling future appointments. If payment arrangements are not made in a timely manner, the account may be turned over to a collection agency.

12. Appointments that must be cancelled require 24-hour advance notification to this office. If you are unexpectedly delayed, please give us a call so we can make arrangements for you to come at a later time or on a different day. There will be a \$35.00 fee charged for any missed appointment that has not been cancelled without 24-hour advance notice.

If you need to make a special payment arrangements, please let us know prior to your appointment. We will accommodate your needs to the best of our ability.

It is our hope that the above financial policy will allow us to provide quality care to our patients. If you have any questions or need clarification of any of the above policies, please do not hesitate to speak with someone in our office.

Patient Disclosures and Consents

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Stepping Stones Pediatrics or the physician individually for services rendered to my dependents or me under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due the Stepping Stones is unable to collect from my insurance carrier for whatever reason.

MEDICAID INSURANCE BENEFITS:

I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Stepping Stones Pediatrics or the physician on my behalf.

AUTHORIZATION TO RELEASE NON-PUBLIC PERSONAL INFORMATION:

I certify that I have received and read a copy of the Stepping Stones Pediatrics Patient Information Privacy Policy. I hereby authorize Stepping Stones Pediatrics or the physician individually to release any of my or my dependent's medical or incidental non-public personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

AUTHORIZATION TO MAIL, CALL OR EMAIL:

I certify that I understand the privacy risks of the mail, phone calls, and email. I hereby authorize a Stepping Stones Pediatrics' representative or my physician to mail, call, or email me with communication regarding my healthcare, including, but not limited to, such things as appointment reminders, referral arrangements, and laboratory results. I understand that I have the right to rescind this authorization at any time by notifying Stepping Stones Pediatrics to that effect in writing.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

CONSENT TO TREATMENT:

I hereby consent to evaluation, testing, and treatment as directed by Stepping Stones Pediatrics physician or his or her designee.

Stepping Stones Pediatrics, PLLC

Patient Name _____ Last First MI DOB ___ / ___ / ___

Financial Policies Authorization

I agree to be responsible for my Stepping Stones Pediatrics expenses; therefore, I authorize my insurance company, attorney, and other parties to pay directly to Stepping Stones Pediatrics, and/or provide any information regarding payment of my bill. I have read, understand, and agree to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

Patient Signature _____ Date ___ / ___ / ___

Parent/Guradian Name _____ Date ___ / ___ / ___

Parent/Guradian Signature _____ Date ___ / ___ / ___

Patient Dislosures and Consents Authorization

Patient Signature _____ Date ___ / ___ / ___

Parent/Guradian Name _____ Date ___ / ___ / ___

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