OFFICE/FINANCIAL POLICY

Our goal at Cornerstone Pediatrics is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and, if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan.
2. On arrival at your first visit, you will need to provide your driver's license or other form of government identification.
3. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physician as of this date, you may be financially responsible for the visit.
4. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and co-insurances. All outstanding balances must be paid prior to scheduling any further visits.
5. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. You are responsible for any balance on your account.
6. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if pre-authorization is required prior to a procedure, and what services are covered.
7. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
8. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
9. Co-payments are due at time of service.
10. Patient balances are billed immediately upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
11. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 60 days will be charged a $10 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.
12. We require 24-hour notice for canceling any appointment. There is a **$35** charge for each appointment that is not canceled or if a 24-hour notice is not given.
13. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
14. We charge **$15** per child to copy or transfer medical records.
15. One school, camp, or sports form will be completed free of charge if brought to your well child check/sports physical. If your child needs any additional forms to be completed, there is a **$5** charge per form. Payment is due when the forms are dropped off. We have a 3- to 5-day turnaround time for forms.

16. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
17. Before making any annual physical appointment, check with your insurance company to confirm the visit will be covered as a well child check or preventative care visit. Not all plans cover annual physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
18. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
19. We require a parent or legal guardian to accompany the child to all visits unless specifically designated on the Authorization to Treat form. Parent must accompany child on first visit.
20. For monthly medication refills, we require 48 hours' notice, during regular business hours. Please plan accordingly. We will not call in medications after hours.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined above.

Patient Name(s) ____

______________________________________ ______________________________________
Responsible party's Name | Relationship to child (parent/legal guardian)

______________________________________ ______________________________________
Responsible party's signature | Date

PRIVACY NOTICE

I have read and understand Cornerstone Pediatrics' Privacy Notice. My signature below is my acknowledgement that I have been provided access to this policy.

Patient Name: ____

Responsible party's name: ____

Relationship to patient: ____

Responsible party's signature: ____

Date: ___________________