GOLD STAR PEDIATRICS, P.A.

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PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

General: Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept cash, check, credit cards, and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company. We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.

Insurance: It is your responsibility to ensure you are in-network with us. If you are, we will bill your insurance. You must present a valid ID and insurance card each time you visit. You must keep all insurance information active and updated. If you do not do this, your insurance information may be wrong, and you may be responsible for the balance rendered. If we have a contract with your insurance company we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company. If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement. Proof of payment and photo ID are required for all patients. We will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company. Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.

Newborn Medicaid Patients: should produce proof of Medicaid coverage as soon as possible. If the child reaches 1 month of age and no proof is provided, and we are unable to verify coverage, the parent/legal guardian will be responsible for the entire bill.

No-Show Policy: Please cancel your appointment 24 hours in advance as a courtesy to us. If you are more than 15 minutes late to your appointment, we reserve the right to re-schedule your appointment. If you are late more than 30 minutes it is considered a No-Show and we will re-schedule your appointment. Patients who have more than 3 "No Show" appointments over 2 years could be discharged from the practice. Of course, there are special circumstances, and we ask for your clear and honest communication. If you have a “No Show” appointment you must pay $25, this fee does not apply to Medicaid patients.

Payment: Payment is due when the work is rendered or when the bill is given to the patient, whichever occurs first. Prompt payment is important. All co-pays are due at the visit time. Any other bills will be collected promptly as well. If you do not pay within 30 days, there will be a late charge. If you are more than 90 days behind, you will be advised to pay balance due within 30 days. If it is not paid, you will be notified that you have 1 month to find an alternative medical provider. During that 30 day grace period, medical treatment will be provided on an emergent basis only.

Returned Check Policy: If payment is made by check, and the check is returned as Non-Sufficient Funds (NSF), or Account Closed (AC), the patient's Responsible Party will be responsible for the original check amount in addition to a $35 fee. Once notified by our office, if payment is not made within 30 days, the account may be turned over to a collection agency and risk being discharged from our practice.

By signing below, you are agreeing to and understand the above financial agreement and you acknowledge that as the parent/legal guardian you are responsible for any charges incurred and agree to pay then as stated above.

Patient Name (Please Print) _____

Responsible Party Name (Please Print) _____

Responsible Party Signature Date_____