Financial Policy
Children's Health Partners, SC

Thank you for choosing Children's Health Partners for your pediatric health care. We are committed to quality health care for your child. A clear understanding of our financial policy is important to our professional relationship. Please see a representative of the practice if you have any questions about this policy.

We charge what is usual and customary for the quality services we provide. Your insurance company may have a sliding scale that may not reflect charges in this area. If we have a direct contract with your insurance company we are bound by their fee schedule.

Your insurance policy is a contract between you and your insurance company. You have certain responsibilities such as paying your copay at the time of service, and providing accurate, timely and complete insurance information. Please be sure we always have your current insurance information so that we may correctly file your claims.

If we are directly contracted with your insurance company we will collect your copay at time of service and bill you for any other charges (deductibles or non-covered services as listed below), which are your responsibility. If we are not contracted with your insurance company you will be required to pay in full at the time of service.

Please note: your insurance company may not cover some charges such as STAT laboratory fees, rapid Strep tests, well child care, vaccinations, flu shots, and other medically indicated services. **If your insurance does not cover these items it is your responsibility to pay for them**. Since we have no way to know all the individual insurance policies, it is your responsibility to contact your insurance if you are concerned as to whether a charge is covered.

When submitting claim information to insurance companies, it is necessary for our practice to release medical and other registration information to the billing agent and to insurance companies of individuals having responsibility for authorization and/or payment of health care services.

APPOINTMENT CANCELLATION/NO SHOW POLICY: In order to efficiently care for all of our patients, we request that you cancel your child's appointment **24 hours** prior to the appointment time. Failure to cancel within 24 hours will result in a No Show fee of $85.00.

I have read the above Financial Policy for Children's Health Partners. I agree to the terms listed above and consent to the release of medical information as outlined above. I understand that my account will be considered delinquent if no payment is received within 60 days and a statement fee of $15.00 per month will be charged.

Signature: _____Date:_____