

**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.

1. As parent or guardian you are responsible for all balances incurred on your child's behalf.
2. Your insurance policy is a contract between you and your insurance company. As such you are responsible for the following:

- a. Verifying that our physicians are in network
- b. Providing Children's Health Partners SC with active, timely, & complete insurance information for primary and secondary insurance plans
- c. Understanding your coverage (i.e. deductibles, copays, coinsurances & services included, in-network medical facilities, etc.)
- d. Paying your co-pay at the time of service
- e. Paying deductibles and coinsurance balances upon receipt of a statement

3. Children's Health Partners, SC will submit claims to insurance companies with whom we are contracted. We will make every reasonable effort to collect from your insurance company based on the contracted fee schedule. Your insurance company may not cover some medically indicated services. **Please know your policy and call if you have questions about services recommended by our physicians.** Any tests performed by outside labs, hospitals, imaging, or other facilities will be billed separately by the provider of those services.

4. Insurance companies require that we code for all services and procedures rendered. If your child is seen for preventative/well child care and acute or chronic conditions are also treated during that visit we may be required to bill for those services separately.

5. Children's Health Partners, SC can not get involved in financial disputes related to divorced parents of a minor child. The parent who accompanies the child to the medical visit is the responsible party and must pay co-pays. Balances due will be billed to the guarantor.

6. We require 3-5 business days for form completion. **Requests for form completion in less than 48 hours will be accommodated whenever possible. A fee of \$20 per form will be charged for this accommodation.** Completion of certain forms, such as FMLA or guardianship forms, may also require a fee.

7. 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 insurance company of individuals responsible for authorization and/or payment of health care services.

8. 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 may result in a No Show fee of \$85.00.

I have read the above Financial Policy for Children's Health Partners, SC. 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. I understand that if my account is referred to a collections agency a 30% collections administration fee will be added to the balance due.

Signature: _____ Printed Name: _____ Date: _____

Patients Covered by this Policy: _____