Ancient City Pediatrics

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Phone: (904) 461-1560

FINANCIAL POLICY

Thank you for choosing us as your child's health care provider. In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions, please discuss them with a member of our billing staff or office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your child's care and treatment.

1. Upon arrival, please sign your child in at the front desk and present your current insurance card at every visit. If you do not have your insurance card or insurance coverage cannot be verified via our online eligibility, you will be required to pay for all services in full at the time of service.
2. According to your insurance plan, Copays, Co-insurance and Deductibles are to be collected at the time of service. We will collect copays, coinsurance, deductibles and any prior balances at check in. Payment is required at the time of service regardless of who brings the child in for the appointment. We will not become involved in any separation or divorce disputes. Babysitters, grandparents, divorced parents, etc. must be prepared to make time of service payments even if they are not the account guarantor. There will be a **$5.00** processing fee charged to your child's account if you are unable to pay these fees at the time of service.
3. If you have no insurance coverage, you will be required to pay for all services in full at the time of service. If you are not prepared to pay at this time, and the appointment is not of an urgent nature, you will be asked to reschedule the appointment.
4. **Please give 24-hour notice if you are unable to keep your appointment.** There is a **$25.00 fee** for appointments that are not cancelled or if 24-hour notice is not given.
5. It is your responsibility to know and understand your insurance plan benefits. It is your responsibility to know if a written referral or authorization is required to see a specialist, if pre-authorizations are required prior to a procedure, if your insurance utilizes a specific lab, and what services are covered. Not all services provided by our office are covered by every plan. In the event that your insurance carrier determines a service to be "non-covered", you will be responsible for the charge.

6. For your convenience, we accept cash, check and all major credit cards. A **$25.00** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred. Payment for these fees must be paid by cash or credit card prior to any future visits.
7. It is not policy of our office to file auto accident claims. You will be asked to pay for these services in full and will be provided with an itemized receipt to receive reimbursement from your auto insurance carrier.
8. Our office is by appointment only. **There will be an additional $30.00 charge for any "walk-in" services.**
9. If medical records are requested by the parent for personal use, there will be a charge of $1.00 per page.
10. We require a one week notice for completion of any forms (camp, school, sports, etc.) that are presented to our office. If forms are not requested at the time of your child's annual well exam, there will be a **$10.00** form fee charged to your account. Payment is due when the forms are picked up.
11. 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.
11. If you are having trouble paying your bill, have questions regarding any prior balance on your account, or are unable to pay on the day your child needs to be seen, please contact a member of our billing staff or the Office Manager prior to your appointment so that we may efficiently review the account, discuss your situation and answer any questions in a confidential manner.

Financial considerations should never prevent a child from receiving the care they need. We strive to remain understanding and flexible of individual circumstances and will do our best to help.

I have read and fully understand the policies of this office regarding payments and insurance. I agree to comply and accept responsibility for any payment that becomes due as outlined previously.

Patient's Name: ________________________ Date of Birth: __________

________________________________ ______________

Signature: Parent or Guardian Date

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Printed Name: Parent or Guardian