FINANCIAL POLICY

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of your visit.

2. **INSURANCE** We are participating providers with several insurance plans. We will file all these insurance claims. A list of these insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance company does not pay the practice within a reasonable period, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage. Be sure to check with your insurer's member benefits department about services and physicians before your appointment. Many web sites have erroneous information and are not a guarantee of coverage.

   You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures billed in this office are considered covered unless limited by your specific insurance policy

3. **LATE CHARGES** of 12% annually will be applied to all patient balances 90 days old or greater.

4. **RETURNED CHECKS** will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a credit card to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action.

5. **ACCOUNTING PRINCIPALS** Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

6. **CANCELLATIONS OR MISSED APPOINTMENTS:** If you do not cancel your appointment at least 24 hours in advance, more than two times, we will assess you a $25 cancelation fee. You will be allowed one no-show appointment before we will assess you a $25 missed appointment fee.

7. **LATE APPOINTMENT:** If you are more than 10 minutes late to your appointment, you will either be asked to wait for an open appointment slot or reschedule for a different day.

8. **RESPONSIBILITY FOR PAYMENT**: I understand that I, personally, am financially responsible to Thrive Pediatrics, PLLC for charges not covered by the assignment of insurance benefits.

FINANCIAL POLICY

9. **ASSIGNMENT OF INSURANCE BENEFITS**: I hereby assign, transfer, and set over directly to Thrive Pediatrics PLLC sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said clinic. I authorize Thrive Pediatrics, PLLC to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to Thrive Pediatrics, PLLC. I authorize Thrive Pediatrics, PLLC to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

10. **SELF PAY PATIENTS OR OUT OF NETWORK PATIENTS:** A 20% prompt pay discount is applied to all full pay payments received within the first payment cycle if patient is self-pay or if we are not in network with your insurance company.

11. **RELEASE OF INFORMATION**: I hereby authorize the and direct Thrive Pediatrics, PLLC to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

12. **COLLECTION FEES**: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

13. **DIVORCED PARENTS of PATIENTS:** By signing below, the parents chose an adult whom is financially responsible for payment of services. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.