Wareham Pediatrics
Boston Children's
Primary Care Alliance

Financial Policy

The following information explains our Financial Policy. A copy of this policy will be provided to you upon request.

1. **Insurance:** We participate in most insurance plans and are happy to file your insurance as long as we are provided with a copy of your card along with accurate information. It is very important to verify your insurance information at each visit. Any remaining balance after insurance pays will be billed to you and is due within 30 days of the statement.

2. **Copayments:** All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. We encourage you to become familiar with your policy. Making your copayment at the time of service will ensure that you meet your contractual obligation. It is also our obligation through our contract with the insurance company to collect copayments at time of service. Uncollected copayments will be billed within 30 days of your visit. Repeated failure to make your copayment may be reported to your insurance company for follow-up.

3. **Copayments for yearly physicals:** A "Well Visit" or "Well Check" does not require a copayment under the *Patient Protection and Affordable Care Act.* For your convenience, your physician or provider may discuss or treat your child for a medical condition during your child's well visit. This saves you from having to make several

trips to our office. **As a result, a copayment or deductible may be required by your insurance company if discussions beyond your child's preventive care occur.** Some examples of this are as follows:

a. Your Provider manages a **pre-existing/chronic problem** (e.g., constipation, ADHD, anxiety, depression, asthma, eczema, or allergies)
b. Your Provider treats your child for any **new problems** they are currently experiencing (e.g., fever, ear pain, sore throat, abdominal pain, cough, wart removal, acute joint pain, rash requiring a work-up, anxiety, ADHD).

For questions related to your benefits coverage and copayments, please reach out directly to your insurance company. Our practice contracts with many different health insurance carriers and we do not know what benefits you may qualify for under your particular plan.

4. **Proof of Insurance:** All patients must complete our patient information form yearly. We must obtain a copy of your child's current valid insurance card to provide proof of insurance.

5. **Claims Submission:** As stated above, we will submit your claims and assist you in any way we reasonably can to help get your claim paid. Your insurance may need you to supply certain information directly, and it is your responsibility to comply with their requests. Please be aware that the balance of your account is your responsibility whether your insurance company pays your claim or not.

6. **Coverage Changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay within 45 days, the balance may be billed to you.

7. **PCP:** If you have an HMO insurance product, you are required to elect a Primary Care Provider (PCP). It is your responsibility to choose a PCP with your insurance company, prior to attending any visits to that PCP office.

8. **Nonpayment:** Patient balances are due within 30 days of the statement date. If no payment is made, reminder letters will be sent after 30 days and again after 60 days. Failure to contact us will result in referral to an outside collection agency and possible dismissal from our office. To avoid such action, you must contact our business office to set up a payment plan. We will extend credit for 90 days unless other arrangements are made.

9. **Payment Methods:** We accept all major credit cards, debit cards, and checks. We also accept credit card payments over the phone. Checks returned for insufficient funds may be turned over to a third party for collection. You will be charged a $25 processing fee on all checks returned for insufficient funds.

Parent/Guardian: _____Date:_____

Patient Name:_____Date of Birth:_____