Patient's Name:________________________
Date of Birth:_________________________
Chart #:_________________________

FINANCIAL POLICY

Thank you for choosing Starlight Pediatrics PLLC. We are committed to providing you quality medical care and building a lasting relationship with you. As part of this relationship, we wish to establish our expectation of your financial responsibility.

Guarantor: All patients 18 years and older carry financial responsibility, with the exception of disabled adults with a legal guardian. In such cases, financial responsibility rests with the legal guardian. The accompanying adult of a minor, 17 years and younger, is financially responsible for services rendered to the minor. We are not party to your child support order or divorce decree.

Self-Pay: Patients without insurance coverage will be required to pay for all services at the time they are rendered. We do offer a discounted rate to self-pay patients. We also offer a payment plan to qualifying patients.

Insurance Collection: Your medical insurance policy is a contract between you and your insurance carrier. As a courtesy, we will bill your medical insurance carrier for the services we provide. We will be diligent in making sure your insurance is filed accurately and promptly. We will always ask for updated insurance, demographics, and contact information at your appointment. Please be sure you provide us with the most up-to-date information and insurance card. Outdated information will cause delays in processing your claim and may lead to out of pocket expenses for you. If you are unable to provide current insurance information, or we are unable to verify coverage through your insurance carrier at the time of service, you will be responsible for payment prior to services being rendered. Should your insurance company pay for those services, we will gladly refund/reimburse you. We will make all the efforts to inform you in advance what potential charges you may have that may not be covered by your insurance, but these charges may change after your claim has been processed. **You are responsible for knowing and understanding your insurance benefits and coverage.**

Co-pays, Outstanding Balances, and Fees: All co-payments, outstanding balances and fees for service not paid by your insurance policy are your responsibility and due at the time services are rendered. Payment of any fees not collected at the time of service, for any reason, is expected within 30 days. Any past due balance not paid will be turned over to a collection agency after 120 days. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorney for collections, that I, the undersigned, shall pay all collection agency fees, court costs and attorney fees, and risk being dismissed from the provider care of Starlight Pediatrics PLLC.

Physical Examinations (Well Visits): Our providers will welcome discussing and/or providing any of the services that may not be covered by your medical health plan during your physical examination. However, please keep in mind that if your medical health care plan does not allow for or cover this additional service on the day of your physical, then you will be responsible for any charges related to that additional service.

No Show / Cancellation Policy: Missed appointments represent a cost to us and other patients who could have been accommodated. Appointments missed / not cancelled at least 24 hours before the appointment time will result in $50 fee. No show / cancellation fees are not covered by insurance and are your responsibility. This fee will need to be paid in full before you will be permitted to schedule another appointment. Four (4) no shows / late cancellations within one (1) year time span are considered excessive and will result in being dismissed from the practice.

Forms Charge: Our providers can help you to complete forms on the same day of the appointment. Requests to complete forms 2 months after the las well visit (school/day care forms, disability forms, sport forms, medications needed for school among others) will incur a $10 fee. This fee is not covered by insurance. Payment is expected before forms will be released.

Medical Records: Request of medical records will incur a $20 fee. This amount is to cover the costs incurred in searching, handling, copying, and mailing medical records to the patient or the patient's designated representative.

Past Due Payments: If you are experiencing financial hardship or are unable to pay your bill in its entirety, please contact our Office Manager to discuss payment options. Patients with a past due balance or who have missed a payment, will not be permitted to schedule an appointment until payment arrangements have been made with our billing department. Balances that remain unaddressed after ninety (90) days will be sent to collections. The patient will be dismissed from the practice and we will no longer be able to provide services.

Returned Checks: A $25 fee will be charged on all returned checks. Additionally, we will no longer be able to accept checks from you for yourself or any members of your family.

High deductible plans: With High Deductible Insurance plans, patient/family is responsible to meet the yearly deductible before the insurance carrier cover any medical expenses. If you have a high deductible plan, you will be required to pay the cost of the appointment in advance. If you don't want to make the payment in advance, we request that you provide us with a valid credit card, so we can charge the amount of the deductible after the claim is processed.

Automobile Accidents: If the reason for your visit is an automobile accident, please know that we will be happy to provide treatment but only on a self-pay basis. Starlight Pediatrics, PLLC will provide you with a detailed receipt upon request in case you chose to file to your insurance carrier personally.

Transfer of care: When transferring care to another provider, we will request and require you to close out any balances due.

Starlight Pediatrics PLLC reserves the right to dismiss any patient from this practice who consistently fails to meet this policy or who refuses to sign this agreement. By signing below, I understand and agree to the terms of this office's financial policy.

Parent/Guardian Signature____________________ Printed Name__________________ Date_________