CATAWBA pediatric ASSOCIATES, PA

FINANCIAL POLICY

Thank you for choosing Catawba Pediatric Associates! We are committed to providing outstanding patient care for you and your family. The providers of Catawba Pediatric Associates, P.A. strongly agree with the American Academy of Pediatrics recommendations that your child receive regularly scheduled checkups and routine follow-up for chronic conditions such as asthma, ADHD and obesity. These visits may include developmental forms, routine labs, and testing of hearing and vision. Please review our financial policy and billing 101 information sheets.

Newborns: ***Please make sure to add our newborn to your insurance plan within 30 days of birth***

Office visits during the first couple of weeks will not be considered a well check by your insurance carrier. We follow AAP guidelines and would like to see your baby 2 days after hospital discharge. At these visits, we check that your baby is starting to gain the weight that he/she may have lost initially. We also check how your baby is feeding, and look for signs of jaundice. These office visits also give us the chance to answer any questions that you may have. These visits are charged as a regular office visit for a weight check and for any concerns that you may have. Depending on how your baby is gaining weight, having jaundice and other contraindications your baby may have approximately 3-6 visits in the first month.

Circumcisions: Our providers are able to perform circumcisions at Catawba Valley Medical Center Newborn Nursery and in our office. Check with your insurance company to confirm this is a covered service as it varies by plan. $250.00 must be paid prior to procedure and will be reimbursed if we receive payment from your insurance company.

Charges:

- We charge for all services and procedures performed by our physicians.
- There is an after-hours charge of $65.00 for our Saturday/Sunday/Holiday visits. This may or may not be covered by your insurance carrier
- If you are here for a routine check-up and other issues arise besides the routine check-up, the provider may bill for separate office visit and you may incur a separate charge.
- **Please be aware that if any outside lab services are required, you will receive a separate bill from those facilities**

Payment:

Please make sure that your insurance information is current at each visit. We will require a copy of your insurance card(s) before services are performed. We file all insurances in a timely manner. Updated insurance information must be given at the time of service. Failure to do so will obligate you for payment of services rendered. We do not become involved in Third Party liabilities. We do not accept an attorney letter of payment guarantee.

- We ask that balances be paid within 30 days of your initial statement, unless prior arrangements have been made.
- Copays will be collected at every visit. We will not collect copays up front for check-ups but you may be billed for one depending on your insurance plan.
- As a courtesy we will file your claims with your insurance company.
- If you have any questions whether we are in network with your particular plan, please contact your insurance company.
- Any outstanding balances will be collected at each visit along with your co-pay.
- Uninsured patients are required to pay $140.00 at the time of service. Any additional balance must be paid when checking out.
- Present your Insurance card at each visit. ***If we are unable to verify your insurance coverage you will be considered uninsured and payment will be required at the time of service***.
- We accept all major credit cards, cash, and checks. Payment may also be made over the phone and online with no additional charge.

Collections:

- We consider your account delinquent if not paid within 30 days from receiving your statement.
- We make a courtesy phone call as reminder that your account is past due.
- After 60 days of non-payment, your account will be considered for collections.
- Once your account is in collections you are at risk of termination from our practice.

I have read the above policy and I understand that I will be responsible for payment for services not covered by my insurance plan.

Signature: _____ **Date:** _____

Patient: _____ **Date of Birth:** _____