



Union Pediatrics, PSC  
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## FINANCIAL POLICY

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Our main focus is to provide first class medical care to our patients. In order to do this, we must receive prompt payment. A financial policy has been developed for the following reasons:

1. To meet financial obligations of the practice
2. To follow terms set forth in insurance contracts
3. To help families understand their financial responsibilities for the services provided by us

**INSURANCE CARDS:** Please bring your child's **current** insurance card with you to each visit. This helps ensure that the proper information is processed, and the appropriate insurance is billed for that day's visit. If your insurance changes, it is your responsibility to check and see that we are providers participating with the plan, and to list us as your primary care physician, if your plan requires this.

**CO-PAYS:** If your insurance requires a co-pay, it must be paid at each visit. The co-pay must be paid by the person who brings the child in for the visit, or payment must be made via phone prior to the visit. This is part of **your** contract with **your** insurance company. **A \$15 LATE FEE WILL BE ADDED TO EACH CO-PAY THAT IS NOT PAID ON THE DATE OF SERVICE.** We accept cash, personal check, Visa, MasterCard, American Express and Discover.

**DEDUCTIBLES:** If your insurance plan has a "deductible", **this amount is your financial responsibility.** We are able to verify the majority of deductible amounts on the date of service, and expect payment for this amount **on the date of service. A minimum of \$75 will be collected.**

**WELL CHILD CHECK-UPS:** Despite the recent health care law changes, many insurance plans still require a co-pay for well child visits. This is your responsibility. Some insurances do not provide vaccine coverage. We are no longer able to provide vaccines to patients at the office **UNLESS** your insurance covers vaccines. For these rare cases, it will be necessary for your child to receive their vaccines at the health department. Please check with your insurance to see if vaccines are covered. In addition, some employer-financed plans do not cover AAP Bright Futures recommended screenings. If this is the case, you will be responsible for these. In most cases, these screenings are less than \$10.

**CANCELLATIONS AND MISSED APPOINTMENTS:** Please cancel or reschedule appointments (well child visits, pre-ops, medicine checks) 24 hours in advance. We reserve the right to charge a **\$25.00 fee** to those who cancel without a 24 hour advance notice, and for any patient who "no shows". **We will charge \$25.00 for any "no show" visit in which the appointment was made the same day.**

### PAYMENT TERMS:

1. Payment of co-pays **AND** outstanding balance is required at each visit.
2. Outstanding balances must be paid within 30 days
3. To any balance over 30 days that has been determined to be your responsibility, a **rebill fee of \$25** will be applied
4. Autopay: Effective 2/1/20, we are instituting an autopay policy. You will be required to either keep a credit card on file (info stored securely, offsite, we will not have your number) or keep a credit in each child's account of \$75. Bills will be sent out electronically, to your patient portal. If not paid within 30 days, your credit card will be charged in full.
5. Payment plans can be set up to avoid collection accounts. Contact us for details. However, failure to adhere to the plan will result in being sent to collections and dismissed from the practice.

**RETURNED CHECK FEE:** There will be a \$35 fee for a returned check. In addition, all future payments will need to be made with either cash or credit card.

**NEWBORNS:** Insurance companies generally allow only *30 days* to add your newborn to your insurance plan. Please call ASAP to get this done. Once you receive your child's card, please provide us with a copy. If you fail to add the baby to the plan, you will be financially responsible for any visits.

**DIVORCE SITUATIONS:** Since we are not a party to your divorce, we cannot be involved in the financial arrangements determined by your divorce decree. The parent who brings the child to the office is responsible for payment due **AT THE TIME OF SERVICE**. We ask that you provide us a copy of the custody agreement. This protects us, you, and your child in terms of HIPPA compliance. If your child has a legal change of name, we must have a copy of the legal document.

**TRANSFERRING RECORDS:** You are entitled, by KY law, to one free copy of your child's medical records. Any additional copies will be assessed a fee of \$1.00 per page. A legal guardian must sign the record release. By law, our office has 30 days to copy the record. We do require that you pick up the record, as they often get "lost" when sent to other practices. If you are unable to pick them up, we do reserve the right to charge a \$5.00 postage and handling fee.

**LETTERS AND FORMS:** There is a charge for all forms not requested at a regular well child check. The charges are as follows:

1. Immunization record: \$5.00
2. Sports form/Camp form: \$15.00
3. School form: \$15.00
4. Same day sports or school form: \$35.00
5. FMLA forms: \$50.00
6. Pre-authorizations for medications: \$5.00
7. Paper billing fee: \$2.00/bill

ONE school/sports/immunization form will be provided per year, given at the well child visit, at no charge. The school and sports form will be saved to your child's 'patient portal. We will not send or fax these to the school, nor will we send immunization records. Since all are available in the patient portal, you can forward them to the school.

No well child exams will be done with an outstanding balance on the account.

I have read and agree to the terms of this financial policy. I will be provided a copy for my records, shall I so desire.

Name-printed: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Names of children: \_\_\_\_\_

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