BOERNE PEDIATRICS

FINANCIAL POLICY

Thank you for choosing Boerne Pediatrics as your child's medical home. We are dedicated to providing the best possible care for your family, and we want you to completely understand our financial policies. Please understand that payment of your bill is considered a part of your child's treatment.

1. Payment is due at the time of check-in for service. We accept Visa/MasterCard Cash and Check.
Insurance plan policy is reviewed at every service. If proof of insurance cannot be verified at time of service, you will be responsible for payment of all services at time of check-in.

2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor—in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within 60 days from time of service, you will be billed for the balance of the payment. If we later receive a check from your insurer, we will refund any overpayment to you.

3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a **co-payment** at the time of your visit. Non-payment of visit co-pay is a violation of your insurance company's contract with you.

4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you on an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

5. 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.

6. Boerne Pediatrics is committed to providing prompt,efficient quality medical care. If you repeatedly miss scheduled appointments, you may be responsible for a missed appointment fee of $25.00. It is important for your child to receive continuous healthcare to ensure proper growth and development.

7. I understand that I am responsible for any customary bank fees charged for returned checks or for insufficient funds.

Please let the office know if you have any questions or concerns.
I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____,_____Date_____

Signature of Parent/guardian Name of Patient