PEDIATRIC PRACTICES OF NORTHEASTERN PA FINANCIAL POLICY

We are doing everything possible to hold down the cost of medical care. You can help by reducing the number of bills we send to you. The following is a summary of our payment policy effective July 1, 2010 and updated on **April 18, 2018.**

ALL PAYMENT IS DUE AND EXPECTED AT THE TIME OF SERVICE.

Payment is **required** at the time services are rendered. This includes:

- Co-payments for participating insurances. (Our contract with your insurance company states that we will collect a co-pay every time a patient presents to the office. If you disagree with this, please contact your insurance company for verification)
- Non-covered services
- Un-Insured (Self-Pay) Visits

Pediatric Practices of Northeastern PA accepts cash, personal checks, VISA and MasterCard. Authorization forms are available for credit card payments.
There is a service charge for returned checks. When using a check for payment, you agree to the following terms: In the event your check is dishonored or returned for any reason, you authorize us to electronically (or by paper draft) re-present the check to your bank account for collection of the amount of the check, **plus any applicable fees** as permitted by state law. We use **Re$ubmitIt** (866-860-5906) to facilitate this process in our office. You shall be responsible to pay any fees or charges associated with a dishonored or returned check plus returned check charge of **$35.00**.

Pediatric Practices of Northeastern PA is not a lending institution, and it is not our policy to extend credit. Patients with an outstanding balance of 60 days or more **MUST** make payment arrangements PRIOR to scheduling future appointments. We realize that financial difficulty is a reality, therefore our **Billing Department is available to assist you Monday - Friday 8:30am - 4:30pm at 570-253-9240 or 570-253-5838.**

Pediatric Practices of Northeastern PA will bill participating insurance companies as a courtesy to you. YOU are responsible to pay any deductible, co-insurance, and co-payments as set forth by your insurance plan. If we have not received payment from your insurance company within a reasonable time-frame you will be expected to pay the balance in full.
YOU are responsible to:

- Make sure all charges are paid whether by you or by your insurance plan, within 30 days of receipt of bill.
- Verify with your insurance company that we are participating with your plan.
- Know what is / is not covered by your insurance plan. This includes any tests or specialist referrals recommended by Pediatric Practices of Northeastern PA.
- Request a referral for a specialist appointment, procedure or testing, allowing 7-10 days advanced notice.

Disclaimer: Our participating with your insurance plan is not a guarantee of benefits or payment. These are subject to all plan coverage provisions, limits and exclusions. There issues are between you, your insurance plan and/or your employer. Pediatric Practices is not responsible for any insurance determination regarding your benefits for charges incurred from referrals to specialists, procedures, and lab work.

I have read and understand the Pediatric Practices of Northeastern PA Financial Policy, revised **April 18, 2018.** I agree to assign benefits to Pediatric Practices of Northeastern PA whenever necessary. I understand by providing Pediatric Practices of Northeastern PA any cell phone number constitutes permission to Pediatric Practices of Northeastern PA for that contact number to be used in the efforts of any communication.

Pediatric Practices of Northeastern PA utilizes Transworld Systems (TSI) to collect balances 90 days or older. I understand that if my account is 90 days overdue it will be forwarded to TSI for collection and I will be assessed an additional fee of $35 in addition to my outstanding balance.

I also agree that if it becomes necessary to forward my account to a collection agent, in addition to the amount owed, I shall also be responsible for the costs of collections, including costs, fees and any percentage contingency fee, **minimum fee charged will be $35.00**.

Signature of Primary Guarantor _____

Signature of Secondary Guarantor _____

Date: _____ Witnessed by: _____

PCC Fame Account Number: _____