** FINANCIAL POLICIES**

Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, especially regarding vaccines, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

**Missed appointments:** Our policy is to charge a**$30 fee for missed appointments** not cancelled within a reasonable amount of time. These charges will be your responsibility and billed directly to you.

**Insurance:** We participate in most insurance plans, including Bayou Health Plans. If you are not insured by a plan we do business with, if your coverage cannot be verified at the time of service, or if our physician is considered “out of network” on your plan, payment in full is expected at each visit. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

**Non-covered services:** We will make an honest effort to verify that the services and vaccines we provide are covered by your insurance. However, there are times when we learn after the service has been provided that it was in fact not covered. Knowing your insurance benefits is **your** responsibility. Please contact your insurance company with any questions you may have regarding your coverage. You are responsible for all non-covered services!

**Vaccines**: We give your child vaccines at your request with the expectation that you or your insurance company will reimburse us in a timely manner. For privately insured patients, these vaccines have already been purchased by us at great expense so that they will be available for your child. If for any reason the vaccine reimbursement is denied in part or in full, you are responsible for the charges. If you are not in agreement with this policy, please let us know so that we can provide you with other options for your child’s immunizations.

**Claims submission:** As a courtesy to our patients who have insurance policies that we have verified, we will file insurance claims on your behalf and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract*.* If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you. If a payment made by you is later paid by your insurance company, we will promptly refund or credit you for any overpayment.

**Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

**Nonpayment:** If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency, and your child(ren) may be discharged from the practice.

**I have read and understand the payment policy and agree to abide by its guidelines. I understand that these policies apply to all children for whom I am financially responsible that are treated at Iberia Pediatrics.**

**DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **SIGNATURE OF GUARANTOR/LEGAL GUARDIAN**