My Kids
Pediatric Partners
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PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing My Kids Pediatric Partners, PC as your pediatric healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies.

Patient or Parent/Legal Guardian Responsibility:

- I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
- Co-payments are due at time of service.
- It is your responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by your insurance carrier.
- We attempt to verify that your coverage is valid at the time of the visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility for payment is yours.
- In the event that my health plan determines a service to be “not payable”, I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If uninsured, I agree to pay for the medical services rendered to me/my child(ren) at time of service.

Insurance Changes

- If you have had any changes in your insurance coverage - even if there is only a small change with the Member ID number, co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

Insurance Payments Sent To You

- If insurance payments are sent to you, you are responsible for forwarding them to our office with a copy of the Explanation of Benefits (EOB) received.

Forms and Fees

- There is a **$10 fee** for the review and completion of school/child care forms not provided at the time of a well child exam
- There is a **$10 fee** for the completion of Family Medical Leave forms. The patient or parent/guardian is required to fill out as much information on the Family Medical Leave form as possible (e.g. reason, duration, etc.).
- There is a **$20 fee** to transfer your and/or the pediatric patient's medical records from My Kids Pediatric Partners, PC.
- A **$25 no show fee** will be assessed for all visits not previously cancelled.
- All returned checks will be subject to a service charge **fee of $25** (this fee is separate from any Bank fees for the returned check).
- Outstanding balances are due within 30 days, unless prior arrangements are made with My Kids Pediatric Partners, PC's Billing Department.
- If a balance is past due for more than 90 days, the parent/guardian or patient is aware that the account balance may be forwarded to a collection agency with an additional collection fee. If this happens, My Kids Pediatric Partners, PC will continue to see the pediatric patient on an emergency basis for 30 days to allow you time to find a new provider.
- We accept cash, checks and credit cards.

Wellness Services Billing Procedures

I acknowledge that during my wellness visit there may be a problem-oriented service performed by a My Kids Pediatric Partners, PC physician in addition to the wellness services. In this case, I understand that two separate charges may be submitted to my insurance and that when applicable, a copay/deductible/coinsurance may be required for charges generated pertaining to the problem-oriented services. Alternatively, I understand I may choose to return for a separate visit to address problem-oriented issues, at which time, my copay/deductible/coinsurance would still apply.

Signature of Parent/Legal Guardian/Patient_____

Print Name of Parent/Legal Guardian/Patient_____

Date:_____