Patient Payment Policy

Village Pediatrics of Chapel Hill Patient Payment Policy

Revised: July 2015

Thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing the best healthcare services to our patients.

We participate with most insurance plans. Your insurance coverage and benefits are a contract between you and your insurance company. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits. We are required to file with your primary carrier only. It is your responsibility to file charges with any secondary insurance carriers for reimbursement.

If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a "self-pay" patient and will be provided documentation to assist you in filing your own claim. We offer a reasonable discount for our cash paying patients. We will give you an estimate of what will be due at the time of service and payment for services is due at the time of service. You will be asked to sign a waiver stating that you have no health insurance and will not be filing with any health insurance carriers. Failure to sign this waiver may result in cancellation of your appointment.

The following are our financial guidelines relative to financial responsibility:

- Please provide a copy of your insurance card at each visit.
- Payment is expected at the time of service. This includes co-pays, co-insurance, and deductibles. Failure to produce payment at check-in may result in your appointment being rescheduled.
- Nurse Visits: Due to recent insurance changes, for all Immunizations a scheduled doctor appointment must be made in advance. Previously, we were allowed to schedule some immunization visits as nurse visits only however, due to changes in insurance reimbursements, nurse visits for shots only will no longer be permitted.
- Co-pays for Well Exams: Beginning September 1, 2012 Village Pediatrics will no longer collect co-payments for any Well Child Exams. We will bill your insurance company at the time of visit. You will be responsible for any outstanding balance not covered by your insurance (this may include a co-pay). This is a new regulation that is dictated by private insurance companies.
- There is a $25 No-Show fee for missed appointments; no fee will be charged for pre-scheduled appointments if appointment is canceled with 24 hours notice; no fee will be charged for same day appointments if appointment is canceled with 2 hour notice. Three or more No Show appointments may result in dismissal from our practice.
- Balances on account must be paid prior to receiving additional services.
- Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.
- Should you have extraordinary financial pressures, we will assist you with a payment plan, agreed to in writing with our billing department prior to services being rendered. No balance over $300.00 can be carried on a family account.
- Accounts will be turned over to a collection agency if past due 90 days or more.
- As a courtesy to our patients we gladly accept cash, check, money order, Visa, Master Card, and Discover.
- There is a fee of $35 for each urgent care visit and a fee of $45 for each urgent care visit on a holiday. Appointments Monday – Friday at 5pm or later, appointments during our weekend hours and same day appointments during a holiday are considered to be "urgent care." This fee will be billed to the insurance we have on file but if it is denied, this fee will become your responsibility.
- In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. We do not bill another individual or estranged spouse for payment.
- Failure to pay balance may result in discharge from the practice.

We welcome the opportunity to participate in your family's healthcare. If you have any questions regarding this policy, please let us know.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

Parent Signature ________________________________ Date ____________

Parent Name (PRINT, please)____________________________

Child's Name (PRINT)___________________________ DOB:____________

Child's Name (PRINT)___________________________ DOB:____________

Child's Name (PRINT)___________________________ DOB:____________

Child's Name (PRINT)___________________________ DOB:____________