KENWOOD PEDIATRICS FINANCIAL POLICY

Thank you for choosing Kenwood pediatrics for your child's/children's healthcare needs. We are committed to providing you with quality pediatric care. Your clear understanding of our financial policy is important to our professional relationship. If you have any questions about our fees, our policies or your financial responsibilities, please ask our office staff who may direct you to contact our billing department. Please take the time to carefully review the following information and return to the front desk with your signature and today's date. It is your responsibility to notify our office of any patient information changes such as address, phone number, name, insurance information, etc..

INSURANCE

We maintain contracts with multiple insurance carriers. It is the patient's responsibility to provide our office with current insurance information. Please bring current insurance card(s) to each visit. We will ask for your insurance card(s) at the first visit and will make a copy for our records. If your insurance changes, we will need to make a copy of the new card. We cannot be held responsible for any insurance change we are not aware of.
Due to the time required to make any changes, if needed, to insurance information, we ask that you do this prior to your visit as office staff cannot. It is especially important that you make sure we are listed as the primary care provider. If current insurance information cannot be verified, you will need to pay for the visit or reschedule until the information can be verified.
Your insurance is a contract between you and your insurance company to pay certain amounts for medical care. Pursuant to contractual obligations, we will file all your claims for you. However, we will not become involved if there is a dispute between you and your insurance carrier. In the event that we receive a denial or no response from your insurance company, we will bill you directly.
If we do not have a participation agreement with your insurance carrier, you will be required to pre-pay an estimated amount. You will need to provide us with all necessary information to properly bill your insurance carrier. You will be responsible for contacting your insurance carrier for any unpaid claims and/or appeals. You are ultimately responsible for all charges and will be billed accordingly.

CO-PAYS

Co-payments are due at the time of your visit PRIOR to being seen by the physician.

DEDUCTIBLES AND CO-INSURANCE

Some insurance companies require the patient to pay a portion out-of-pocket before paying for any services. Balances related to unmet deductibles and estimation of co-insurance, as per the contract you have with your insurance, is to be paid at the time of the visit. Additional balances due, if applicable, will be billed to you after the insurance carrier has processed the claim.

UNPAID/OUTSTANDING BALANCES

We ask that full payment be made at the time of service unless prior arrangements have been made. Please ask our office staff to set up payment arrangements if necessary. Any overdue balances may be considered for further collection activity. Please be aware that services may be limited until balances are paid in full or other arrangements have been made. Payments are due at the time of receipt of any mailed bill. Payments can also be made at the office with cash, charge or check. The charge for any returned check is $25.00 payable by cash or charge.

NO FAULT/WORKERS COMPENSATION

It is the patient's responsibility to provide our office with the necessary information needed to properly submit charges. If you fail to do so, the fees mandated by NYS will be changed to reflect our private fees and you will be responsible for payment. Some no-fault carriers have deductibles on medical charges, for which the patient is responsible. We will bill the patient if there are any unpaid balances after the claim is processed.

SELF PAY

If you are uninsured, please ask the office staff for information on obtaining health insurance. If you are seen prior to obtaining insurance, you will be responsible for remitting payment at the time of service prior to being seen by the physician, unless other arrangements have been made.

I have read and understand the above office policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended as necessary by the practice without notice.

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