IVY CHILDREN'S CLINIC FINANCIAL POLICY FORM

Please read our Financial Policy and Patient Consent Form and initial where indicated. Your initials by each item indicates your understanding and agreement.

_____**All insurance copay and deductible amounts are due in full at the time of service**.

_____ **UPDATED INFORMATION**: Please be certain you have updated all demographic and insurance information at every visit. We are only able to bill the insurance provided to us at the time of service. If you become aware that the incorrect insurance was billed or you have new insurance that was not provided, you must provide it within 30 days of the date of service. We may not be able to properly submit claims if the information is not provided to us in a timely manner. Payment for the services rendered will then become patient responsibility.

_____ **GUARANTOR**: We can only bill the parent that signed the financial authorization paperwork. We are unable to bill anyone who is not listed as the guarantor on the account. It will be responsibility of the parent to forward the bill to another party.

_____ **PATIENT RESPONSIBILITY**: We will submit to primary and secondary plans that we participate with, however, we cannot guarantee payment. It is your responsibility to be familiar with your insurance benefits and confirm our participation. Any services that you receive that are not covered by your plan will be patient responsibility. Please call your insurance if you have any questions.

_____ **AFTER-HOURS TELEPHONE CALLS**: There will be a $15 charge for each after-hours phone call.

_____ **NO SHOW FEE**: Ivy Children's Clinic will charge a $25.00 fee for failure to keep scheduled appointments. Please call our office 24 hours before a scheduled appointment to cancel or reschedule an appointment that you will not be able to keep. Please be aware that your insurance will not cover any no-show fees.

_____ **NSF CHECKS**: There will be a $25.00 fee for all checks returned to us for non-sufficient funds. In addition, we will no longer accept checks and will request payments by cash or credit card.

_____ **COLLECTIONS FEE**: Please be aware that if there has been no attempt to settle a balance on a patient account after 60 days of which it becomes due, the account will be accessed a $25.00 collection fee.

Patient Name ___________________________ DOB________________

Parent Signature_________________________ Date________________