HERITAGE PEDIATRICS
Caring for the Next Generation

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Financial Policy - 2018

1. Co-Payments, co-insurance, deductibles, and personal balances are due at the time of service regardless of who brings in the child. (This includes divorced parents, grandparents, older siblings, nannies, babysitter, etc.)
2. Well visits may be covered at 100% and in most cases do not require a co-payment. However, if you discuss/examine other medical conditions pertaining to your child within the same office visit you may be charged a co-pay by your insurance company for which you will be responsible.
3. For your convenience, we accept cash, checks and credit cards including Visa, MasterCard and Discover. We do not accept American Express or postdated checks. Any returned check will result in a $25 service charge and all future payments will be required to be cash or credit card.
4. **Insurance is your responsibility. You MUST present a valid insurance card at every visit. We are not responsible for obtaining or maintaining ID numbers, or knowing all the ins and outs of your plan.** Please note that if you do not present us with an active insurance card, you may be required to pay for the visit in full at the time of service.
5. If we are unable to obtain eligibility within 24 hours, any balances will be applied as a personal balance and collected from the account holder.
6. Claims denied by the insurance companies will be billed to the responsible party. If there are any questions you may dispute them with your insurance company.
7. Prompt Pay for cash/self pay patients. Effective January 1, 2015, all self/cash paying patients will be given a 30% "prompt pay" discount if the balance is paid in full on the date of service. If you are not able to pay your balance in full on the date of service, to the compliant with the Texas law, we will have to charge the patient the full amount (100%) of the visit. However, this does allow you to make payments or pay at a later date (within 90 days), if necessary

Assignment of Benefits

I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance, and any other medical/health plan, to issue payment check(s) to Heritage Pediatrics, PLLC. For medical services rendered to myself and/or my dependents regardless of my insurance benefits. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information

I hereby authorize Heritage Pediatrics, PLLC to release any information necessary to insurance carriers regarding my illness and treatments, process insurance claims generated in the course of examination of treatment, and allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from Heritage Pediatrics on behalf of myself and/or my dependents, and understand by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

I have received, reviewed and agree to comply with the following:

- Financial Policy, Assignment of Benefits, Authorization to Release Information
- Notice of Privacy Practices

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Signature of Parent/Legal Guardian Date