Concord Children's Clinic

PATIENT FINANCIAL POLICY

Thank you for choosing Concord Children's Clinic as your health care provider. We are committed to providing you the best quality medical care. As a part of this relationship, we wish to establish our expectation of your financial responsibility. The following is a statement of our Financial Policy:

FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE.

We accept: Cash, Checks and Credit Cards

INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to:

- Ensure our providers actively participate with your insurance carrier.
- Know your benefit coverage, as well as your dependents, prior to receiving services.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission requirements set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.

Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at time of treatment. If your insurance carrier considers us "out of network" or does not participate with us, you are responsible for payment in full at the time of service.

To summarize, your financial responsibility may include:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pended claims due to lack of patient and/or guarantor information
- Non-Insurance and/or out-of-network benefits

If you fail to receive an Explanation of Benefits (EOB) from your plan within 45 days of treatment, we suggest you contact your insurance plan to determine benefits, as they may not have made payment. Payment not received in 60 days from the date of service, may be transitioned to patient responsibility and you may be required to make other payment arrangements.

SELF PAY

If you do not have insurance, you will be considered a “self-pay” patient. “Self-pay” patients will be given an estimate of what will be due and required to pay for all services at the time they are rendered. Payment is expected in full at the end of your visit.

CO-PAYMENTS
Payment is expected at time of service. Failure to produce payment at check-in may result in your appointment being rescheduled.

HEALTHSHARE PROGRAMS
If payment from these types of programs is not received by our office within 60 days, the amount will be transmitted to patient responsibility and you will be required to make payment arrangements

DIVORCE DECREES/RULINGS
In the case of services provided for minors, the individual who initiates services for the child will be responsible for payment. This office is not a party to your divorce decree. We will not bill another individual or estranged spouse for payment. Copayment is due at the time services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment, it is the authorizing parent’s responsibility to collect form the other parent. Western Wake Pediatrics will not act as a mediator in this effort.

MISSED APPOINTMENTS
Unless canceled at least 24 hours in advance, our policy is to charge $50.00 for missed initial ADD appointments. We cannot file nor will insurance plans pay for this charge. Please help us serve you better by keeping or canceling your appointment in advance.

FORM FEES
When dropping off forms to be filled out by our office, please allow us 5-7 business days to complete the form and advise you when the form is ready for pick up. There is a $5 form fee for our office to complete FMLA forms.

PAST DUE PAYMENT
If you have a financial hardship, or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. You may reach the billing department at: 704-784-1010 extension 115.

COLLECTIONS
Any past due balance not paid will be turned over to our outside collection agency after 90 days.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

I have read and agree to this Financial Policy:

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Signature of Patient or Responsible Party

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Child’s Name and Date of Birth

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Date