Financial Policy

Due to the new federal regulations regarding patient rights we have been mandated to implement the following policies as they apply to our office.

All payments are expected at the time of service

Payment is required at the time services are rendered, unless other arrangements are made in advance. This includes applicable co-insurances and co-payments for participating companies. Co-payments must be paid at the time of service regardless of who brings the child into the office. In cases (such as divorce) where the custodial parent is not the insurance holder, the person accompanying the child is responsible to pay co-payments at the time of service. Our office will not bill for co-pays. Marblehead Pediatrics accepts cash, personal checks, VISA and MasterCard. There is a service charge of $10.00 for all returned checks.

Patients with an outstanding balance of 60 days past due must make arrangements with the billing office prior to scheduling well child appointments. School, camp and/or sports forms will not be provided for patients with accounts 60 days or more overdue unless arrangements for payment have been made with the billing office. Accounts over 90 days overdue will be considered seriously delinquent and referred to our Collection Agency. We do realize that there are extenuating circumstances and that people have financial difficulties and we are willing to work with you to help you resolve the problem. Please call the office and speak to the office manager to make special arrangements.

Insurance

Your insurance card must be presented at every visit. We bill insurance companies as a courtesy to you. It is your responsibility to notify the office of any insurance change. It is essential to enroll newborn infants with your insurance carrier within 30 days of the date of birth. Unless this is done, the child has no insurance coverage under your policy. If you fail to do this within 30 days following birth you will be billed for the services that we have provided. We do not bill secondary insurances for co-pays. If we do not receive payment from your insurance company within 60 days from the date of service, you will be expected to pay the balance in full. You are ultimately responsible for all charges. If you need assistance or have questions, please contact our billing department.

Responsibility for Medical Care

Every child under the age of 18 must be accompanied by a parent/legal guardian or by an adult who has obtained written consent for the child's treatment from the parent/legal guardian. The exception is an adolescent presenting for confidential services which we are permitted by state law to provide without consent of the parent.

No Shows/Late Cancellations

Broken appointments are a cost to us, to you and to other patients. Cancellations are requested 24 hours in advance. We reserve the right to charge for missed appointments or late cancelled appointments. Our staff will attempt to call to remind you of the appointment; however, the responsibility to keep the appointment is yours. Persistent missed appointments may result in discharge from the practice.

School/Camp/Sports Forms

Our school/sports form will be provided to you after your child's yearly exam. Please keep the original and photocopy it for future use. There is a $5.00 administrative fee per copy for our office to provide you with additional copies.

Medical Records Transfer

If you request a copy of your child's medical records to be sent either to you or to another physician, there will be an administrative fee of $15.00 to be paid at the time the request is made. Please allow up to two weeks for the processing of this request.

I have read and understand the FINANCIAL POLICY OF MARBLEHEAD PEDIATRICS. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I may also be responsible for the fee charged by the Collection Agency for cost of collections. I certify that the insurance information I have given is correct. I authorize release of any medical information necessary to process a claim. I authorize payment made directly to MARBLEHEAD PEDIATRICS.

Child's name_____ DOB_____

Signature_____ Date_____
Patient/Parent/Guardian