The Pediatric Center - Financial Policies

We appreciate your selection of our practice for your children's medical care. To prevent any possible future misunderstanding, we have prepared the following summary of our billing policies.

The parent or guarantor (insured member) is responsible for payment for services provided by the Pediatric Center at the time they are rendered. The only exception to this policy is if the Pediatric Center has contracted with a managed care organization/HMO/PPO to accept the insurance payment as payment in full, after you have met your deductible, if any, and made all co-payments, if required. **We will require a copy of your insurance card and billing information. Please bring the card with you to each visit. If you join or change plans, please inform us immediately!! If you fail to inform us of any changes in coverage, you will be responsible for payment for services rendered.** We will balance bill you per your insurance plan.

It is our policy that the person bringing the child to our office is responsible for payment at the time of the visit for services rendered, regardless of which parent has the ultimate legal obligation to pay for medical care. It is the parents' sole responsibility to settle these financial matters between themselves and caregivers.

$25 LATE FEE/PER MONTH - for all balances over 60 days.
BILLING FEE - for co-payments not paid at the time of service - $10 (in addition to the co-pay)
MISSED APPOINTMENT FEE - for physical appointments not cancelled 24 hrs. in advance - $50 and $100 for "counseling" appointments not cancelled within 48hrs.
TELEPHONE CONSULTS - After hours calls to our "Pediatric Triage" Center, between 9pm & 8am, will be directly billed to you, $20/each.
COpy OF MEDICAL RECORDS - first copy is free, thereafter charges per CT law, currently at $.65 per page plus postage.
RECORDS RETRIEVAL - $25 and up for "off-site" records (more than 4 years after the last date of service). Records may be destroyed 7 years after last date of service per CT Law.
****Forms - all completed forms are free and will be mailed if a stamped, addressed envelope is provided. Allow one week. "Urgent" forms that are needed to be picked up will be $20/child. No faxes in or out, please.**
****VFC/STATE VACCINES - available for those who qualify, $21/administration fee/dose.**
RETURNED CHECK FEE - is $30.

Responsible Party's Statement, Authorization and Assignment of Benefits:

I have read all the above and agree that, regardless of my insurance status, **I am ultimately responsible for the balance on my account for any services rendered.**

I authorize payment directly to The Pediatric Center for any and all medical benefits otherwise payable to me under the terms of my insurance. I also affirm that I will reimburse The Pediatric Center for any payments my insurance company may have sent to me in error. **I understand that I am financially responsible for all co-payments, charges not covered under my insurance benefits and the above Fees For Service.**

Should your account become delinquent and turned over to our collection agency, we will start the process of dismissal from our practice after two months in collection. In the event that any legal action is brought to collect my account or any portion thereof, I agree to pay a reasonable sum for attorney's fees in addition to costs and disbursements as provided by statute.

A photocopy of this authorization shall be considered as effective and valid as the original.
I authorize the release of any medical information necessary to process claims.

Childrens' Names ______________________________ Date ______________

Signature ______________________________ Relationship, ______________

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