OLSON PEDIATRIC CLINC
FINANCIAL POLICY

Thank you for choosing Olson Pediatric Clinic. We are committed to providing the best care possible. This goal is best achieved by letting you know in advance of our financial policy, which is an agreement between the doctors of the practice and the child's parent or guardian or a patient 18 years and older. Your clear understanding of the financial policy agreement is important to our professional relationship. Please read this carefully and if you have questions please do not hesitate to ask a member of our billing department. We require a signature to document that you have read and understand these policies.

INSURANCE

- **Current insurance card must be presented at check in for every visit.** ***If the insurance company that you designate is incorrect, you will be responsible for payment.***
- We will not bill another insurance carrier supplied at a later date, if it is past the timely filing period for that insurance company. If a child is insured by more than one insurance company, our office needs to have all insurance companies' names on file.
- According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
- **Co-Payments are due at time of service. Co-payments are a contractual obligation between you and your insurance company.**
- If a sibling is added to an appointment, they will have a separate charge and co-payment collected if required by insurance.
- If your insurance company does not cover a service, the amount must be paid in full within 30 days of denial from the insurance company. If not insured, the amount must be paid in full within 30 days from date of service.
- If you have no insurance, payment for an office visit is to be paid at the time of service. A 15% discount is given if the visit is paid in full on the day of the appointment.
- Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to understand your benefit plan, including needs for referral or authorization for specialty care, vaccine coverage, lab tests and other services that may be required. **Please note: physicians follow accepted national guidelines when determining your charges. They must code based upon what services were provided and cannot take into account particular health plan benefits.**

BILLING

- We provide you with an itemized statement each month when there is a balance due. We accept cash, checks, MasterCard, Visa and Discover.
- We will charge your account a $25 non-sufficient funds charge if your check is returned to us for insufficient funds.

- We appreciate the difficulties involved in divorce and court orders. Olson Pediatric Clinic **will not** participate in disputes between custodial and noncustodial parents. We will refer to the responsible party, who signs the financial policy, for reimbursement of any amounts owed to our clinic.
- Balances are due within 30 days of the first statement, unless prior arrangements have been made with the billing department. Please call if you have questions about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings.
- Registrars will be collecting payments at check in on all accounts with balances that are more than 30 days past due.
- If you are having difficulty paying your bill, please discuss the situation with the billing department.
- Should your account remain outstanding more than 90 days, a final letter will be issued. Balances not paid in full within the 10 days of the date on the final request letter may be forwarded to a collection agency.
- If your account is forwarded to a collection agency, your account will be charged a $150.00 processing fee and your family will be dismissed from the clinic. In order to allow you time to find a new source of medical care, the physicians will continue to see your child on an emergency basis only for the next 30 days, providing visits are paid in full at the time of service.

FINANCIAL AGREEMENT

We must emphasize that as pediatric providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know the benefits your insurance plan provides for you.

The undersigned agrees with the terms and conditions listed in the financial policy. By refusing to sign this financial policy, I agree to pay in full at the time of service. I certify that the information I have given to Olson Pediatric Clinic is accurate. I hereby authorize Olson Pediatric Clinic to furnish my insurance company all they may request concerning the patient's present illness or injury. I hereby assign to Olson Pediatric Clinic all benefits for service rendered.

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Patient (Parent of Legal Guardian) Date