



Financial Policy

Effective September 2021

1. **It is our pleasure to process each insurance claim** through our billing department; however, **it is your responsibility to verify coverage** prior to your appointment. Not all insurance plans cover all pediatric services. The fact that an insurance plan may not pay for a particular service does not mean that your child should not receive it. In the event your insurance plan determines a service to be “not covered,” you will be responsible for the complete charge. To facilitate a claim, a copy of your driver’s license and insurance card will be required.

Initials: _____

2. **Co-payment is due at the time of service.**

Initials: _____

3. **Self-pay Patients:** Payment on the day of the examination is due. Kindly refer to the “Fees for Service” price list.

Initials: _____

4. **Out-of-Network Provider:** If your insurance company does not have a contract with Dr. Roma Franzia Pediatric Practice, you are considered to be out-of-network. You will be responsible for the out-of-network balance owed.

Initials: _____

5. **Cancellation:** An appointment may be cancelled up to **4 hours prior** to the scheduled time.

Initials: _____

6. **No Show:** If a scheduled appointment results in a “No Show,” **a fee of \$75** will be charged to your account.

Initials: _____

7. **Walk-in appointment:** If your child arrives at Dr. Franzia’s Pediatric Practice without a scheduled appointment, your insurance company will be charged an additional \$25/emergency visit.

Initials: _____

8. **Prescription refills:** Anytime a patient requires a prescription refill without an appointment, your insurance company will be charged **\$35 for the medical documentation.**

Initials: _____

9. **Speaking with a physician during office hours:** A simple conversation with a physician during office hours is free. A medical decision making conversation requiring documentation, and perhaps a prescription, is a **“Tele” charge** that will be billed to your insurance company which will result in a co-pay/balance that you will be responsible to pay. Most insurance companies have allowed for this charge due to medical/legal responsibility.

Initials: _____

10. **Speaking/texting/emailing with a physician after office hours:** A telephone/text call will be responded by a physician as soon as possible. Emails will be answered the next day. A “**Tele**” **charge** will be billed to your insurance company which will result in a co-pay that you will be responsible to pay. Most insurance companies have allowed for this charge due to medical/legal responsibility.

Initials: _____

11. **Divorced/Separated Parents:** Due to the complexity of these situations, our policy regarding payment on your account is the **responsibility of the custodial parent**. If you have a settlement that states you split medical bills, it will be your responsibility to work that out with your former spouse.

Initials: _____

12. **Outstanding Balances:** Once an insurance claim is processed, you will receive a statement. If a balance on your statement is due, it would be appreciated if the payment was made within 30 days. Failure to pay the balance in full within the 30 days of the statement date will result in a late charge of 1.5%. Late charges will accrue monthly until the remaining balance is paid. If you are experiencing financial hardship, please contact our billing specialist, Ritu, at (224) 365-8401 or email: Ritu@DrRomaFranzia.com to make payment arrangements.

Initials: _____

13. **Notification of Possible Non-Covered Services:** There may be services that Dr. Franzia's Pediatric Practice deems necessary for the maintenance of good health that may not be covered by your “in-network” health insurance. Our practice participates in a vast number of different policies and are not able to know all exclusions on your policy. If your policy declined payment on these services, my office will apply the contracted discount to your services. Payment will be your responsibility.

Possible Non-covered Charges: Denver Development, Immunizations, and Nebulizer Rentals.

Initials: _____

I, _____ (**name of responsible payer**), authorize and request my insurance company to pay directly to Dr. Franzia's Pediatric Practice my insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s). I have read and understand Dr. Roma Franzia's Pediatric Practice's Financial Policy.

Signature _____

Family Name _____

Date _____



Credit Card Payment

Before a charge is processed, you will be notified.

After a charge is processed, a receipt will be given or mailed to you.

This credit card information will be entered into our Electronic Medical Records System and then shredded for security. Only the last 4 digits of this credit card will be available to our practice.

Method of Payment Mastercard Visa Discover American Express

Credit Card Number _____

Expiration Date _____ **CVV Code** _____

Signature _____

Name _____

Date _____