#3 Financial Policy

Effective September 3, 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. If you have not provided accurate information within 5 business days of the appointment, the full amount will be your responsibility. To facilitate a claim, a copy of your driver's license and insurance card will be required.

    a. Initials: _____

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

    a. Initials: _____

3. **Self-pay Patients:** A routine examination is $250, not including immunization(s) or test(s) required. A sick examination is $125. Payment on the day of the examination is expected.

    a. Initials: _____

4. **If your insurance company does not have a contract with Dr. Franzia,** you are considered to be with Dr. Franzia as an **out-of-network provider.** You will be responsible for the out-of-network balance owed to Dr. Franzia.

    a. Initials: _____

5. **CANCELLATION POLICY:** an appointment may be cancelled up to ***4 hours prior*** to the scheduled time.

    a. Initials: _____

6. **NO SHOW POLICY:** if a scheduled appointment results in a "No Show," **a fee of $75** will be charged to your account.

    a. Initials: _____

7. **On-Call: A charge of $35/call/child or Tele visit** will be billed to your insurance company. Most insurance companies have allowed for this charge due to medical/legal responsibility and documentation.

    a. Initials: _____

8. Due to strict medical malpractice laws, **anytime a prescription is called in for your child during office hours**, your insurance company will be charged **$35/call/child** for the medical documentation.

    a. Initials: _____

9. **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.

    a. Initials: _____

10. **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 office at (224) 365-4197 to make payment arrangements. Accounts with a balance that have not made a payment for 6 months will be sent to a collection agency.

    a. Initials: _____

11. **Notification of Possible Non-Covered Services:** As your physician, I want to provide you with the best care possible. There are services that I feel are necessary for the maintenance of good health that may not be covered by your health insurance. Our office tries our best to notify prior to services rendered of non-covered services. Because of the vast number of different policies our office participates in, we 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
    Nebulizer Rentals

    Initials: _____

I, _____**(name of responsible payer)**, authorize and request my insurance company to pay directly to the doctor 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 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.

Method of Payment ◯ Mastercard ◯ Visa ◯ American Express

Credit Card Number _____

Expiration Date _____

Signature _____

Name _____

Date _____