

Pt. Name \_\_\_\_\_

**Northeast Pediatrics and Adolescent Medicine  
Billing Policy and Procedure**

Thank you for choosing Northeast Pediatrics and Adolescent Medicine for your family's health care needs. It is our goal to provide the best possible medical care to your children. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

As a courtesy to you, we will be happy to bill your insurance company for the services rendered on your visit date. In order to do that, it is essential that you bring your insurance card to every visit and communicate with our reception staff any changes to your insurance coverage or billing information.

**Payment is due at the time services are rendered unless we participate with your insurance. If we participate with your insurance carrier, your co-pay will be collected at the time of the visit.** Your insurance coverage is a contract between you, your employer and the insurance company. You are ultimately responsible for the bill regardless of your insurance coverage. If your insurance requires a deductible to be met, it will be your responsibility to know what that deductible amount is and whether or not the deductible has been met.

Insurance companies often will pay for services based on a time schedule. Well Child visits are one example. While we make every effort to help you, the number of insurance plans we deal with and the fact that your employer may change contracts without our knowledge prevent us from being able to take responsibility for advising you whether a service is covered. It is your responsibility to be knowledgeable of your insurance plan and its limitations.

We realize that temporary financial hardships arise sometimes that may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for assistance. **Our Billing Manager is available to discuss issues of payment and assist you in making the necessary payments to avoid interruption of services or possible termination of care. Payment for any balance greater than 45 days will be expected at the time of subsequent visits. Non-payment may result in your balance being sent to collections.**

As your health care provider, we must emphasize again that our relationship is with you and your family, not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, the charges are your responsibility from the date services are rendered.

We appreciate the time you have taken to read our billing policies. If you have any further questions, please feel free to contact our office to speak with our billing department.

**I, \_\_\_\_\_, have read and understand the above written patient policy regarding Billing policies at Northeast Pediatrics.**

\_\_\_\_\_  
Parent Signature

\_\_\_\_\_  
Date