Effective - June 2016
Revised - Jan. 2018

Pediatric Choice Clinic
Financial & General Patient Policy

Thank you for choosing our practice! We are committed to the success of your child's medical treatment and care. Please understand that payment of your bill is part of this treatment and care. We believe that a good relationship is based on understanding and open communication. Our staff will make every effort to answer any question you may have concerning your balance. For your convenience, we have answered a few of the frequently asked practice and billing questions below. If your question is not listed or additional information is needed, please ask to speak to someone in the Billing Department.

FAQ –

What is Required at the First Visit?

A parent or legal guardian MUST accompany minor patients for the initial visit. If the parent/guardian chooses to have additional adults, other than themselves, accompany the minor patient to a subsequent appointment, those names have to be listed in the patient's file prior to the appointment. Underage siblings/ friends cannot be included on the list. The patient will not be seen if the person accompanying them is not listed.

All new patient paperwork, including medical history, release of information, financial and billing information, must be completed prior to the child seeing the provider. Please have the current insurance card(s) and parent/ legal guardian's driver license available when completing the new patient paperwork.

What Insurance Do We Accept?

We accept all major insurance plans from our area as well as Tenn-Care policies. Check with your insurance company to ensure we are in-network and what services are covered prior to the appointment. Please notify the front desk of any changes to your insurance information.

What forms of payment are accepted?

All co-pay payments are due at time of service. We accept payment by cash, check, Visa, or MasterCard.

What is My Financial Responsibility for Service?

We bill your insurance carrier at the time of service. It is extremely important that the insurance information we have on file is up to date. If a claim is denied or delayed for incorrect information, you may be responsible for the entire balance.

Claims that are delayed and have not been paid within sixty (60) days will be automatically billed to you.
Patients/Parents/Guardians that do not present current insurance information at the time of service will be asked to pay the current flat rate for an office visit or reschedule the appointment.

Will I Get A Statement?
Statements are generally generated every 6-8 weeks after the insurance company has responded to the claim. Payment is expected in full upon receipt of the statement. If you are unable to pay the balance in full, please contact the billing department to schedule payment arrangements. Accounts will be considered past due thirty (30) days following the date of the statement unless payment arrangements have been made. Late accounts may be charged a late fee. Unpaid accounts beyond ninety (90) days are considered delinquent and may be escalated to the collection agency, incurring additional late/ collection/ court fees.

What if I am Unable to Keep or Miss an Appointment?
Please notify our office at least twenty-four (24) hours prior to or as soon as you become aware that you will be unable to keep your appointment. We reserve the right to charge a missed appointment fee if we are not notified prior to the appointment. Three (3) non-cancelled, missed appointments are grounds for patient discharge.

What if I am Late for an Appointment?
If you are more than fifteen (15) minutes late for an appointment, we will make every attempt to work your child in but we may have to ask you to reschedule the appointment. Repeated excessive late appointments are grounds for patient discharge.

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I have read, understand, and agree to the Financial Policy provided to me. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Pediatric Choice Clinic.

I authorize Pediatric Choice Clinic to release pertinent medical information to my insurance company when requested to facilitate payment of a claim.

Date____

Patient
Name____

Parent/ Guardian
Name____

Signature____