Somerset Pediatric Group
FINANCIAL POLICY

We are committed to providing your child with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. We will file all insurance claims for you with any carrier that we participate with, however, you are ultimately responsible for your child's charges.

1. Our office participates with a variety of insurance plans.

   It is your responsibility to:

   - Bring your insurance card at every visit.
   - Pay your Co-Payment at the time of service; this is an insurance company requirement. Payment can be made by cash, check or credit card. We accept VISA, MasterCard, Discover and American Express. We do not bill for Co-Payments. All co-pays not paid at time of service will be assessed a $10 fee.
   - Pay in full for any medical care or services that are not covered by your insurance plan.
   - Complete or update the Demographic information sheet every year

2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service. Your child will be a "Self Pay" patient in our office. We offer a discount to "Self-Pay" patients, if the charges are paid at the time of service. "Self-Pay" patients receive a 30% discount on sick and well visits (other than vaccines).
3. If your insurance plan is an HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists a physician from a different practice, we will see your child, but you will be "Self-Pay" and required to pay at the time of service until the PCP has been changed to one of our physicians.
4. You are financially responsible for any amount not covered by your child's plan.
5. If you have questions about your insurance, the business office will be happy to help (908) 725-5530 Option 1. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.

6. If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance.
7. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.
8. Late Arrival/No Show Policy

   Appointments are scheduled specifically for each patient. If you arrive late for your appointment, you may be asked to reschedule to another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" for an appointment, you may be charged a $35 "no show fee" per child.
9. There will be a $10.00 charge for all forms that are brought in after the child's well visit. We can complete the form the same business day if you must have it back that soon at a charge of $25.00. Forms brought in the day of the child's well visit exam will NOT be charged.
10. There are many different insurance plans, some have a co-pay requirement at the time of service and some that do not require a co-pay after a set amount of out-of-pocket expenses have been met. Since we are not able to verify this before the charges are submitted to your insurance company, we will request a co-pay at every visit and will be happy to refund your co-pay if one is not required.

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I have received the Somerset Pediatric Group Financial Policy.

Child's Name_____

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Parent/Guardian (Print Name)

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Parent/Guardian Signature Date