200 Griffin Road, Suite 12A | Portsmouth, NH 03801 | 603.457.7040
www.puddledockpediatrics.com

Financial Policy

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided, as each insurance policy is different and it is therefore impossible for us to know what are your particular benefits may be. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Copayments and Deductibles:
Depending on your insurance policy, a copayment and/or deductible or coinsurance may be required at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. Co-insurance may apply even after meeting your deductible. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

Patients without Insurance Coverage/Non-covered expenses:
We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit. The same discount will be applied to any non-covered charges for patients with insurance, if paid at the time of service. This discount cannot be applied toward the “patient responsibility” portion of *covered* charges, as those charges are already discounted through the contract we maintain with your insurer.

Financial Arrangements:
Because we realize that every person’s financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (Returned

checks will be subject to a $35 returned check fee.) If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Appointments/Cancellations:
We gladly reserve appointment times for you and appreciate that you have chosen Puddle Dock Pediatrics for your care. As a courtesy, we will remind you of your appointment by calling and/or sending a text or email to remind you of your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patients' valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up.

We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no-show fee of $50. After three no-shows or same day cancellations, your family may be dismissed from the practice.

Divorced/Separated Parents and Custodial Arrangements:
Puddle Dock Pediatrics does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

Patient/Parent/Guardian Responsibility:

- I understand that whomever accompanies my child to their appointment has authorization to consent to medical care as needed, *and is responsible for payment of medical services.*
- I acknowledge my responsibility for payment of all services provided by Puddle Dock Pediatrics in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Assignment and Release:
I authorize payment to be made directly to Puddle Dock Pediatrics by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.
I have read and understood the above policy and agree to it.

Name (please print): _____ Date: _____

Patient's Name and Birth Date: _____

Signature of Responsible Party (Guarantor): _____

Relationship to Patient(s) (please check): ___ Parent ___ Self ___ Other: _____

Witness Signature: _____

Note: *The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.*

Credit Card on File

Puddle Dock Pediatrics is committed to making our billing process as simple and easy as possible. We therefore recommend that a valid credit card be kept on file with the practice. Credit cards on file can be used to pay copays and other charges (such as toward the deductible or for non-covered services) at time of the visit. Once processing the visit with your insurance is complete, your card may be charged the outstanding amount that your insurance company determines to be "patient responsibility", as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email. If your payment is declined, we will call you.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

By signing below, I give Puddle Dock Pediatrics permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Name (please print): _____ Date: _____

Signature of Responsible Party (Guarantor): _____

Notice of Privacy Practices Written Agreement:

I also acknowledge that I have read a copy of Puddle Dock Pediatrics' Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Puddle Dock Pediatrics has a link to the Notice of Privacy Practices on the practice website (www.puddledockpediatrics.com).

Name (please print): _____ Date: _____

Signature of Parent/Guardian/Patient: _____