Bristow Pediatrics

Financial Policy

It is our goal to provide cost-effective, compassionate, pediatric care for your family. As a courtesy, we will file your insurance for you. We will need a current copy of your insurance card in order to process your claims. Without your card, you will be responsible for full payment at the time of service. Please be advised that whoever accompanies the child to their appointment is responsible for payment at the time of service. This includes co-payments and deductible amounts. We will assess a $5 fee if the co-payment is not paid at the time of service. We will also defer well-child care until all balances are paid in full. We require a credit card be kept on file with our office. Balances after insurance adjudication will be charged to your credit card. Unpaid balances over 60 days old, without payment arrangements, will be sent to collections and we will not be able to continue to care for your child. You will also be responsible for any additional amounts incurred as a result of collecting past-due balances.

You are also responsible for understanding what is included in your insurance policy. If your insurance requires a prior authorization, you must obtain it before being seen in our office or you will be responsible for any charges incurred.

All balances not covered by your insurance are your responsibility. If we have not contracted with your insurance carrier, you must pay the balance in full. We will provide documentation for you to submit to your insurance carrier for reimbursement.

Self-Pay patients will receive a 25% discount if the full balance is paid at the time of service. Self-pay patients must pay $50 upon check-in and the remaining balance at check-out. If your visit is less than $50, we will refund the difference. Payment plans are available.

A $25 service charge will be applied to your account for all returned checks. Subsequent payments will need to be paid in cash, money order, or credit card. Your account will also be charged a $25 fee for appointments cancelled without 24 hours notice. There will be a $10 fee for Medical Records.

I have read, understand, and accept the above insurance and billing procedures.
This waiver is effective for 1 year after the date signed.

Patient Name _____

Responsible Party Signature: _____ Date: _____

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