

**Poole and Thomas Pediatrics, PLC**

**FINANCIAL POLICY  
EFFECTIVE June 1, 2022**

Thank you for choosing and entrusting Poole and Thomas Pediatrics for your child(ren)'s care. Drs. Poole, Thomas, Crowley and Goodsell are dedicated to providing excellent care to your children at a fair and reasonable rate. In order to provide this care, we have adopted the following financial policy. We recognize that the cost of health insurance has increased; unfortunately, our costs to provide that care have risen significantly as well.

It is our goal to eliminate future misunderstandings in regards to our billing and payment policies. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We participate with most major insurance plans. While we will work with you to submit your claims to your insurance company, please note that ultimately your insurance is a contract between you and your insurance carrier. Each insurance policy is individual and it is your responsibility to understand your benefits, eligibility dates, and what is and is not covered by your plan. If claims are not paid within 90 days, the unpaid balance becomes the responsibility of the parent/guardian. We will make every effort to work with you to file insurance claims and resolve any outstanding balances in a timely manner.

Please be aware that you MUST provide updated demographic (address and phone numbers) and insurance information to our office. Up-to-date information is needed for both parents. We must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible, along with the effective dates of your new policy. If previous visits need to be re-filed to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance company. If you do not provide us with the correct insurance information at the time of the change, then your claims may be denied due to timely filing by your insurance and those claims would then become your financial responsibility. You will also be responsible for any denied charges due to incorrect information.

Co-pays, Co-insurance and Deductibles will be expected at time of service. Private Pay Patients are expected to pay in full at the time of service. If there is an outstanding balance on your account and you are being seen in the office, the balance will be required to be paid in FULL at time of service. NO EXCEPTIONS. In the event of a separation/divorce, the parent bringing the child for an appointment is responsible for the co-pay or balance, which is due during that visit to our office. If one parent specifically is responsible for medical bills, we must be notified of that by both parties. Whichever parent/guardian signs this form, you will be held responsible for any amount owed and it will be your responsibility to collect from the other party.

Returned Checks: There will be a returned check fee of \$50 for any check.

Weekends and After Hours: There is an additional fee for appointments on late evenings, weekends, and holidays that may or may not be covered by your insurance. Any unpaid charges will be your responsibility.

Payment: We accept cash, check, debit cards, Visa, MasterCard, Discover, and money orders. Our staff or billing office may contact you at any of the numbers provided by you in an attempt to resolve any outstanding balances.

You can expect to receive one billing statement from our billing office and payment is due within 30 days. If you have not made a payment within 30 days from receipt of the statement, you will receive a letter asking for payment. If we do not hear from you at that time, your account will be turned over to a professional collection agency. This will result in termination of the physician/patient relationship.

Assignment of Benefits/Authorization: As parent or legal guardian, I authorize payment of medical benefits directly to Poole and Thomas Pediatrics, PLC for services rendered. I further agree to be fully responsible for all lawful debts incurred for these services.

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Signature of Parent/Legal Guardian

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Date

Child(ren)'s Name and DOB:

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