Palatine Pediatrics

Financial Policy

Thank you for choosing Palatine Pediatrics. As part of our partnership with your family to provide comprehensive medical care to your child, we have outlined your financial responsibilities for your child's healthcare. Please read this policy thoroughly and complete below.

Responsible Parties As the parent or legal guardian, you are responsible for payment of all medical services provided to your child. Health insurance serves as a form of payment, but does not replace your financial responsibility. If your insurance carrier has not paid their portion within 60 days, the full balance will be your responsibility. All children within a family are part of a family account. Balances incurred for one child will be due before services are provided to any child within the family.

Insurance Coverage Insurance contracts are between a patient and their carrier. It is the responsibility of the parent(s) or legal guardian(s) to know and understand their individual insurance policy. This includes knowing what services are covered, what limitations your policy has, and what your financial responsibility is.

Primary and Secondary Insurance Our office bills primary insurance only. If your child is insured by Medicaid and another insurance carrier, Medicaid is the secondary insurance.

Payment Due All copays are collected at the time of service. Payment for coinsurance, deductibles and non-covered services are due at the time of service unless a credit card, Health Savings Account (HSA) card, or Flex Spending Account card is on file. Payment is due by the person or parent who brings the child in, regardless of divorce decree arrangements.

Payment Plans Payment plans for sick visits are available for families with financial hardship. Payment plans require a credit card on file until the balance is paid, and must be completed within 90 days.

Collections Failure to pay your bill will result in the balance being sent to a collection agency. Accounts sent to a collection agency will be responsible for a 25% collection agency fee in addition to the outstanding balance and any applicable attorney fees. Once an account is sent to collections, services will no longer be provided to any member of the family.

Returned Checks Returned checks will incur a $35 Non-Sufficient Fund charge in addition to the balance owed. Checks will no longer be accepted in the future.

Sick Charges with a Well Check Illnesses, injuries or significant problems addressed during a well check-up will incur an office visit charge in addition to your child's well exam. You will be responsible for your office visit copay, coinsurance or deductible. ADHD, asthma, ear infection, sore throat, skin conditions, injuries and pain are some, but not all, conditions that may incur an additional charge.

Self-Insured and Health Exchange Policies Self-insured plans and health exchange plans must be paid through the current date in order for our office to accept them as a form of payment. If not paid to date, payment is due at the time of service.

In compliance with our insurance contracts, all copays are collected at the time of service. Payment for deductibles, coinsurance, and non-covered services are due at the time of service unless we have a credit card or health payment card on file.

Please choose ONE payment option:

Option 1

☐ **I would like to leave a credit card, HSA, HRA or Flexible Spending card on file.**

I authorize Palatine Pediatrics to charge my card on file after my insurance carrier has processed my claim and has indicated the amount I owe. I understand that leaving my card on file is my consent to these charges and that I will not receive notification prior to my card being charged. I understand that I will receive a notification after my card is charged and my payment receipt will be available on the patient portal for my records. I understand that leaving my card on file does not revoke my ability to dispute charges with my carrier if I disagree with their determination of benefits.

Option 2

☐ **I would like to pay at the time of service in cash or credit card**

I understand that my portion of my child's bill is due at the time of service in cash or credit card only. I understand that the amount I am charged is based on the services my child receives and the fees my insurance has set forth. I understand that my insurance will be billed for all services provided. I understand that I may receive an additional bill later if my insurance indicates I owe more than the amount collected at my visit.

Parental Consent:

I have read, understand, and agree to Palatine Pediatrics' Financial Policy. I understand that all fees, terms, and conditions are subject to change without notice.

Printed Name of Parent/Legal Guardian's: _____ Date: _____

Signature of Parent/Legal Guardian: _____