FINANCIAL POLICY

BASIC POLICY: Payment for service is due in full at the time service is provided in our office. Copayments will be collected upon sign in. Copayments and any other payments due for services are the responsibility of the parent accompanying the child. In cases of divorce we will not bill a parent that is not present at the time of the visit. If the parent/guardian does not have the copay for a well or non sick visit you may be asked to reschedule the visit.

FOR PATIENTS WITH INSURANCE: We bill most insurance carriers for you if proper paperwork is provided to us. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. It is the patients responsibility to notify their insurance plan yearly of any other insurance coverage (whether you have other insurance coverage or not).

NONCOVERED SERVICES: Any care not covered for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

WELLCARE AND/OR PREVENTATIVE CARE: Periodic preventive health services may or may not be covered under your health insurance policy. However, they may be required by your physician.

MISSED APPOINTMENTS: In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You may be charged for missed appointments or dismissed from the practice.

INSURANCE PATIENTS: SIGNATURE ON FILE & ASSIGNMENT OF BENEFITS I request and assign to **STEPHEN G. NELSON M.D., PA** all insurance benefits otherwise payable to me for services rendered. I authorized the doctor to release all information necessary to secure the payment of benefits.

I understand my signature requests that payment be made to the provider of services, and authorize release of medical information necessary to secure payment of benefits. I authorized the use of this signature on all my insurance submissions whether manual or electronic. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

______________________________ **PARENT/GUARDIAN NAME (please print)**

______________________________ **PATIENT'S NAME**

______________________________ **PARENT/GUARDIAN SIGNATURE**

______________________________ **DATE**

I have read, understood and agreed to the above financial policy for payment of professional fees. The patient is ultimately responsible for all professional fees.

______________________________ **Signature**

______________________________ **Date**