Anita Sabeti, M.D. Pediatrician

Financial Policy and Authorization - Please sign

Insurance: We accept many of PPO insurance plans. As a courtesy to our patients, we will bill your insurance on your behalf. Your insurance plan is a contract between you and your insurance company. **You are responsible** for knowing your policy, eligibility at the time of service, in or out of network coverage, services covered, number of well visits allowed, your copay, deductible, coinsurance and so forth.

-**Co-pays:** will be collected at the time of service.

-**Outstanding balance:** You will receive an invoice for your share of cost determined by your insurance plan, including deductible, coinsurance and other outstanding balance not paid by insurance and is considered patient's responsibility. You should provide us with your preferred way of communication. Invoices are due in upon receipt.

- Credit card on file: We require a valid Credit Card on File (CCOF). Your CCOF will be charged for any unpaid invoice **automatically** after 30 days and a receipt will be sent to you. Your card data is secure. Only a temporary token representing your card is shared with the business. The actual card data is stored with the payment processor and follows Payment Card Industry Data Security Standards (PCI-DSS).

-Outstanding charges: For outstanding charges not paid within 90 days, we reserve the right to discontinue scheduling appointment.

-Interest: Monthly interest and penalty will be charged on unpaid balances over 30 days.

- Collection: Outstanding charges not paid within 120 days will be sent to our collection agency and may be reported to the major credit bureaus. Once an account has been sent to the collection agency, care in our office will be discontinued for all family members.

- Returned check fee: There is $25.00 penalty and $25.00 reprocessing fee for returned checks.

-No show fee: There will be $50.00 "no show fee". Cancellation made prior to 24 hours of appointment is free of charge.

-If you are experiencing financial difficulties: please contact our billing department to discuss installment payments. A regular monthly payment schedule can avoid collection procedures and enable continuation of care in our office.

-Insurance error: If you believe your insurance company has made an error in processing a claim, we ask that you contact your insurance company as soon as possible. If your company determines that an error has been made, please contact our billing staff so that we can resubmit the claim.

-Extra charges: You are responsible for any additional charges not covered by insurance; like after hour charges, school and sport physical forms, medication refill request, e-visits and

telephone consults not covered by insurance, no show fees, etc.. Also additional issues addressed at well check appointments may need to be reported and billed separately. Your insurance company may require that a separate co-payment be paid for additional services provided at the visit.

Authorization:

I understand that it is my responsibility to understand the benefits provided in my insurance plan. I am responsible for insurance copayments at the time of my visit, and I am also responsible for any outstanding balance once my insurance claim has been processed. I am responsible to provide the office with updated insurance information.

Parent's Name:. . . . . .Relationship to patient: . . . . . .

Date: . . . / . . ./ . . . . . Signature: . . . . . .

I authorize release of any medical information to my insurance carrier necessary for processing of claims.

Parent's Name:. . . . . .Relationship to patient: . . . . . .

Date: . . . / . . ./ . . . . . Signature: . . . . . .

I authorize payment of medical benefits directly from my insurance carrier to the treating physician for services provided.

Parent's Name:. . . . . .Relationship to patient: . . . . . .

Date: . . . / . . ./ . . . . . Signature: . . . . . .

☐ I agree to place my credit card on file and authorize use of my credit card to be run by Best Care pediatrics, DBA, Anita Sabeti, M.D. for the charges mentioned above upon receipt of an invoice.

☐I refuse to provide credit card and will pay for visit in full. I will be reimbursed after my insurance processes the claim.

Parent's Name:. . . . . .Relationship to patient: . . . . . .

Date: . . . / . . ./ . . . . . Signature: . . . . . .