# HOLLAND PEDIATRIC ASSOCIATES, PLC

926 Washington Ave., Building C • Holland, MI 49423 • www.hollandpediatrics.com • P: 616.393.0166 • F: 616.393.0167


# FINANCIAL POLICY

We are committed to providing you with the best possible care and customer service. We ask for your help by understanding and cooperating with our financial policy. **Please read thoroughly, complete the portion on the back and give to our front desk to be scanned into your child's electronic medical record. If you would like a copy for your own records, please ask the front desk for a copy.**

**CO-PAYS & BALANCES ARE DUE AT THE TIME OF SERVICE**

**Types of payment accepted: Cash, Checks, Visa, MasterCard, Discover and American Express**

## INSURANCE CARDS

We ask that you present your child's current insurance card at each visit. This ensures we have accurate, up-to-date insurance information for each patient. At a minimum, we obtain a new copy for the patient's chart each calendar year.

If your child's insurance changes, it is your responsibility to verify that we (Holland Pediatric Associates, PLC) are participating providers with that plan. We request that you list the patient's Primary Care Physician (PCP) if your specific insurance plan requires this. It is also your responsibility to notify our office of any changes to your child's insurance plan.

## HEALTH INSURANCE INFORMATION

Your health insurance is a contract between you and your insurance company. We participate with many insurance companies, and we are unable to know each policy holder's requirements. It is your responsibility to check with your insurance carrier to see if a specific physician participates with that insurance plan and what your insurance coverage is.

For those insurance plans that we **DO** participate with we will process the claims electronically. For insurance plans that we **DO NOT** participate with the patient is expected to pay for services and seek reimbursement on their own from their insurance company. We are happy to provide you with an itemized receipt which you can submit to your insurance company.

You need to be aware of your carrier's rules, regulations, and payment policies. If your health insurance states that you are responsible for paying a co-pay, Holland Pediatric Associates, PLC **MUST** collect a co-pay at time of service. This is part of your contract with your insurance company. If co-payment is not made at the time of service, your child will be refused to be seen at that time.

All minors (under 18 years of age) must be accompanied by a parent or guardian. The **accompanying adult** is responsible for payment of the account according to the policy outlined above.

If a claim comes back as "Pending Info", it means the insurance company needs more information. Contact the number on the back of the insurance card. **You** need to contact the insurance company. We (HPA) are unable to do this.

Some services are not a covered benefit and are not paid for by your insurance company. If a service is "not a covered benefit" by your insurance company, you will be required to pay for those services. Once you are signed up and connected to our patient portal, you can pay balances through the portal.

You are responsible for the timely payment of your account if your insurance does not make payment within 30 days.

## BILLING PROCEDURE FOR NEWBORNS

Insurance companies generally only allow 30 days to add your newborn to your insurance plan. Please call your insurance as soon as possible to get your newborn added. Once you receive your child's insurance card, please provide us with a copy. If you fail to add your baby to your insurance, you will be financially responsible for any visits.

## PAYMENTS

There are different ways you can make a payment. Payments are accepted in person, by mail and by directly calling our billing department at 616-393-9598. If you are connected to the patient portal, you can also conveniently make a secure payment on the portal.

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## RETURNED CHECKS FOR INSUFFICIENT FUNDS

If we receive a returned check for insufficient funds, we will immediately reverse the payment on your account and will also charge a $20.00 fee to your account.

## COLLECTION ACCOUNTS

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. If you have a balance on your account, we will send you a monthly statement. If your account is over 90 days past due without contacting our Billing Department to discuss payment options, the account will be turned over to collections. If your account is sent to our collection agency, your family will be terminated from the practice.

If you're having financial difficulties, please let us know. We can help you by setting up a monthly payment plan. A monthly payment plan can help avoid collection procedures and enable continuation of care. Contact our billing department for more information (616-393-9598).

## CHILD'S NAME AND BIRTHDATE

_____ _____ _____

First Name | Last Name | Birthdate

## CURRENT INSURANCE INFORMATION

Please provide the patient's insurance information in full, before signing.

### PRIMARY INSURANCE

_____ _____ _____ _____

Name of Insurance Company | Contract Number/Employee ID | Group Number | Start Date of Insurance

_____ _____ _____ _____

Policy Holder's Name | Policy Holder's Birthdate | Relationship to Patient | Employer

### SECONDARY INSUR0ANCE

_____ _____ _____ _____

Name of Insurance Company | Contract Number/Employee ID | Group Number | Start Date of Insurance

_____ _____ _____ _____

Policy Holder's Name | Policy Holder's Birthdate | Relationship to Patient | Employer

## ACKNOWLEDGEMENT AND SIGNATURE

I understand and agree that, regardless of my insurance, I am ultimately responsible for the balance on my account for any professional services rendered. I have thoroughly read all the information on this sheet and am in agreement with everything. I also understand that the terms of the Financial Policy may be amended by the practice at any time without prior notification.

**NOTE:** Stepparents cannot sign for stepchildren. ONLY biological/adoptive parents and legal guardians can sign.

Name (printed): _____ Relationship to Patient: _____

First Name Last Name

Signature: _____ Today's Date: _____



DISPONIBLE EN ESPAÑOL SI USTED LO NECESITA.