Louisville Pediatric
SPECIALISTS

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Financial Policy

We would like to take this opportunity to welcome you to our practice and tell you that we are grateful that you have chosen us to provide for your children's healthcare needs. Our goal is to establish a good physician-patient relationship. Letting you know in advance of our policies allows for a good flow of communication. Please review the following information carefully.

Co-payments and co-insurance are due at the time at each visit. We are not permitted to bill for co-payments or waive these payments. We must collect all co-payments and deductibles designated by your insurance carrier.

WE ACCEPT CASH, VISA, MASTERCARD, AMEX, HSA OR CHECK.

PATIENT RESPONSIBILITIES*:*

It is your responsibility to give our office current and up to date information. This includes legal name, current address, and telephone number changes, as well as current insurance information.

It is your responsibility to know your insurance plan's policies and guidelines. Every insurance plan is different. You should know if your insurance company has a preferred lab or hospital, which we are required to use for your services to be covered.

It is your responsibility to contact your insurance company to verify that any physician you see in this practice is a participating physician with your insurance company, and with your specific plan.

If you are insured by an insurance company with whom we have a contractual agreement, you will be responsible for your co-payment/ co-insurance at the time of service. You will also be responsible for any non-covered services at the time of service. If you have a deductible, payment is due at the time of service until your deductible is met.

If you are not covered by insurance, payment is expected at the time of service. Our billing coordinator will assist you in setting up a payment plan if necessary.

All accounts over 120 days old are subject to collection review.

OUR COLLECTION POLICIES:

We will collect your co-payment and co-insurance at the time of your office visit, and we will file your insurance for you. After your insurance company pays its portion, if any,

the remaining balance then becomes your responsibility. You will receive monthly statements until payment has been satisfied. Failure to respond within 120 days to the statements with payment in full, or call to make payment arrangements with us, will result in your account being placed in collections. This could adversely affect your credit as well as result in termination of medical services to your children.

I have read and fully agree to the terms of this financial policy.

Patient Name(s)_____

Responsible Party Member's Name_____Relationship_____

Responsible Party Member's Signature _____ Date _____

PLEASE UNDERSTAND THAT YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN OUR OFFICE.

If you have any questions regarding your billing statement, please contact our billing department for assistance at 502-935-5633.

----------Please ask for a copy for your records----------