TLC PEDIATRICS, PC
REVERE-WINTHROP PEDIATRICS

FINANCIAL POLICY

1. Co-payment: Co-pays are due at the time of service regardless of who brings the child into the office. For your convenience, we accept cash, personal checks, debit card, VISA, Master Card and Discover Card. There is a service charge of $20 on all returned checks.

2. Accuracy of information: To help us keep our billing costs low, please notify us of any changes in your insurance, address or telephone number at the time of check in. Always bring your health insurance card to the visit.

3. Insurance payment: As a courtesy, we submit claims to your insurance company. However, any insurance payment not received in 60 days will become your responsibility. It is essential that you enroll your newborn with your insurance carrier within 30 days of the date of birth; otherwise your child will not have coverage under your policy.

3. Missed appointments: We request that cancellations be made 24 hours in advance. We reserve the right to charge a fee for missed appointments or late cancellations.

4. Outstanding balance: Well Child appointments, school, camp or sports forms will not be provided for patient with balance that are over 60 days unless arrangement for payment have been made with our billing office. If you are experiencing financial difficulties, our billing office will work with you to set-up a payment plan.

5. Self-Pay Patients: All charges must be paid in full before leaving the office unless other arrangements are made in advance.

6. Your financial responsibility: Co-pays, deductibles, co-insurance, claims denied by your insurance, any services rendered that are not covered by your insurance and any accrued charges.

7. Forms and Medical Records Fees: $5 for each additional copy of physical form, $10 for copies of medical record located in the office, $15 for copy of immunization faxed from our storage facility and $35 for copies of complete medical record from our storage facility.

I have read, understand and accept TLC Pediatrics, PC's Financial Policy. I authorize the release of patient's medical information to the insurance companies for the purpose of filing insurance claims.

Name of Patient: _____ DOB: _____

Legal Guardian: _____

Signature: _____ Date: _____