Tri-County Pediatric Associates, P.C. Financial Policy

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and copayments for participating insurance companies. **Copayments must be made at the time of service regardless of who brings the child into the office. We do not make exceptions for divorced or separated parents.**
Tri-County Pediatrics accepts cash, personal checks (Massachusetts only), VISA, Mastercard and Discover. Patients with an outstanding balance of 60 days overdue must make arrangements for payment with the billing office prior to scheduling well appointments. School and camp forms, medical reports and the preparation of other reports requiring office time will not be provided for patients with accounts 60 days or more overdue unless arrangements for payment have been made with billing office. We realize that people have financial difficulty. Please call the office to make special arrangements. All accounts 90 days overdue will be considered seriously delinquent and will be referred for further action, which may include a collection agency.

INSURANCE

Your insurance card must be presented at every visit. If upon verification of coverage the patient is found not to have insurance coverage on the date of a well visit, you will be asked to reschedule the appointment or make a payment equal to one half of the total charge. If we do not receive payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are ultimately responsible for all charges. We do not bill auto insurance companies. Patients seen as a result of an auto accident will be expected to pay all charges on the date of service and submit the bill to their auto insurance company. Your time of service receipt includes all information necessary for submitting claims to your insurance company. It is the patient's responsibility to be aware of and understand the requirements of their individual insurance coverage.
If you need assistance or have questions, please contact our billing office between 9:00am and 5:00pm, Monday through Friday at 781-344-3791.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE/REFERRALS

If the patient is enrolled in a manged care insurance plan (HMO or MassHealth) which requires a referral, you must receive that referral from our office before seeing a specialist. This must be done in advance with the referral coordinator allowing 3-5 business days for processing.

NO SHOWS/LATE CANCELLATIONS

Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations require 24 hours prior notice. We reserve the right to charge for missed appointments or appointments canceled with less than 24 hours notice. Excessive abuse of missed appointments may result in dismissal from the practice.

SCHOOL/CAMP/SPORTS FORMS

One school/camp/sports form will be provided to you after your child's yearly exam. Keep the original and photocopy it for anyone requesting a health form. Additional copies of this form will be made at an administrative charge of $10 payable at the time of pick up. If more than twelve months have passed since your child's last well child exam, we will not be able to fill out any type of health form for your child, including work permits. Work permits require 48 hours to process and must be dropped off during normal business hours completely filled out. Incomplete work permits will not be signed.

CREDIT CARD AUTHORIZATION

I authorize Tri-County Pediatric Associates to keep my signature on file and to charge my VISA, Mastercard or Discover as instructed by me. Tri-County Pediatric Associates will not, however, keep any credit card numbers on file. Credit card numbers must be furnished each time you instruct our billing department to make a transaction. This authorization is valid until canceled through written notice to Tri-County Pediatric Associates.

I have read and understand Tri-County Pediatric Associates' Financial Policy.
I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency for costs of collection.
I certify that the insurance information I have given is correct and any changes will be reported to Tri-County Pediatric Associates.

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Signature of Parent or Legal Guardian Date