



St. Louis Pediatric Associates, Inc.

PATIENT FINANCIAL POLICY

www.stlpeds.com

Accepted forms of payment: Cash, Check, Visa, Master Card, Discover, American Express, or Money Order

Insurance: A current insurance card must be presented at every appointment. We will file a claim for all insurance companies we are contracted with (see complete list on our website). We only accept contractual write off if we are contracted with the patient's specific insurance company. Remember that your insurance policy is a contract between you and your insurance company. **The patient is responsible for any non-covered charges and should always be familiar with their insurance benefits.**

Assignment of Benefits: I hereby authorize my insurance benefits be paid directly to St. Louis Pediatric Associates, Inc., realizing I am responsible to pay all non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers and/or specialists referred by the physicians.

Copayments: Copayments are due at the time of service. **This is an agreement between you and your insurance company.** If a copayment cannot be paid at the time of service, there will be an additional \$25 service charge added to the account.

Office Procedures and Labs: Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

Responsible party: It is our policy that the responsible party is the parent who signs this agreement. This is the parent who will receive all bills from our office. All copays are due at the time of service by the person bringing the child into the office.

Self-pay (no insurance): Payment is expected at the time of service for all charges.

Budget billing: Budget bills can be set up to help in certain financial situations. They are paid each month with an amount agreed upon by the billing department. These plans are to help pay off an unexpected balance due to deductible or coinsurance. They are for the balance due at the time of setting up the budget plan. Any other balances accrued will receive a separate statement and are expected to be paid upon receipt.

Collection Fees: Accounts turned over to our collection agency will have an additional collection agency fee that is 25% of the reported balance. You will be responsible for this fee in full. Accounts turned over to our collection agency will show up on your credit report.

No Show Appointments: There is a \$25 charge for missed appointments. Appointments should be cancelled or rescheduled at least 24 hours in advance so another patient can utilize the appointment time.

Forms and letters: There is a \$10 fee for each form consisting of 1-4 pages in length and a \$25 fee for forms 5+ pages to be completed by our office. It can take up to 10 business days for the form to be completed and returned. There is a \$25 fee for letters completed by physician.

Medical Record Copies: There is a base and per page processing fee for copies of medical records. This fee changes annually. This fee is in accordance with federal and state statues. Please contact us for the current fee. This fee will be waived if records are sent directly to another physician's office. It can take up to 4 weeks to process a medical record request.

Over the counter prescriptions: There is a \$5 fee for each request for over the counter medication prescriptions needed to support a patient's HSA and FSA reimbursement process. This fee is due at the time of the request. (See full policy on our website)

Split vaccine: There is a \$35 charge for each visit if you choose to split your vaccines into multiple visits.

After hours: If your child is seen after our regular business hours, a \$20 fee will be charged in addition to any treatment on that visit.

I have read and understand St. Louis Pediatric Associate's entire financial policy as stated above and I agree to its terms. I also agree that such terms may be amended by St. Louis Pediatric Associates at any time.

Signature of responsible party (in accordance with SLPA financial policy)

Date

Printed name of responsible party _____

Child(ren)'s Name(s): Please include last name

