Pediatric Care Center

4504 Estate Diamond, Ste 3, Christiansted, VI 00820
Tele: 340·719·0681 Fax: 340·719·9039

FINANCIAL POLICY

Thank you for choosing Pediatric Care Center as the health care provider for your child. Our practice is committed to providing the highest level of quality care. It is extremely important to our professional relationship that you have a clear understanding of our financial policy and your responsibility in helping us to maintain the terms of our policy. Pediatric Care Center has adopted the following financial policy. Please take a moment to read and sign as a validation that you understand the terms as outlined.

Contracted Insurance Co-Payment/Co-Insurance/Deductible

Pediatric Care Center participates with most of the insurances that are contracted with VI Equicare Inc., and will file all charges incurred with the appropriate claims office. We have agreed to accept the rates from these plans, however, all co-Insurance and co-payments are your responsibility and are payable at the time of service as per your contractual obligation with your insurance company. Pediatric Care Center Is contractually obligated and will collect the co-payments prior to each visit with your doctor.

The cost of billing co-payments often exceeds the copayment amount, therefore, you will be charged a $10 processing fee if you are unable to pay your co-payment at the time of service. Pediatric Care Center will collect in full any amount incurred per visit until your deductible has been met.

Today's health insurance policies and coverages offer more options than ever. Each patient is responsible for knowing his/hers plan benefits package, co-payment, co-insurance, deductible, non-covered services and restrictions.

Newborns

Newborns are usually covered by the mother's or father's insurance for the first 30 days of life. The baby must be added to the insurance policy as soon as possible within the first 30 days of life for insurance to continue for your child. If you are unable to present a card or we are unable to verify coverage after your child is 30 days, you will be asked to pay in full unless we can ascertain coverage.

Non-Contracted Insurances

If we do not participate with your insurance plan, payment in full is expected at the time of service. If you choose, we can submit a claim form to your insurance company as a courtesy to you.

Secondary Insurance

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary Insurers will pay a fraction of what your primary carrier pays. We also will bill your secondary carrier as a courtesy. You are however, responsible for any balances after your Insurances have not covered.

Hospital Visits

A claim will be submitted to your Insurance company following the hospital discharge of your child. Any balance remaining will be due after receipt of payment and/or explanation of benefits from your insurance company.

No Insurance

Full payment is due at the time of service. If you are unable to pay your balance In full, please make arrangements with our billing department. Failure to make prior arrangements will result in additional fees due to the cost of processing the bills.

Payment/Service Charges

We accept cash, credit cards (VISA or MasterCard), or debit cards (with or without logo).

In the event that there are any outstanding payments after service there will be a service charge fee of $10.00 if payment Is not made by the end of the business day.

There will be a $25 service charge for all returned checks.

Any outstanding balances are due within 30 days. If you experience circumstances out of your control, please call our office and we will be happy to establish payment arrangements with you. All accounts with unpaid balances over 60 days will be assessed a $15.00 monthly statement fee. All balances over 90 days past due will be sent to a collections agency. Should your account be sent to a collection agency, you will be financially responsible for any collection fees and fees that this office incurs throughout the process utilized to collect the delinquent balance.

ADDENDUM

NO SHOW AND LATE CANCELLATION FEE FOR SPECIALY SERVICES

Since we attempt to schedule patient appointments as quickly as possible, it is very important that patients keep their appointments or give us at least 24-hour notice if they must cancel or reschedule. This will give other patients the opportunity to schedule needed appointments. This serves to notify you that we have adopted a No-show/Late Cancellation Fee of $60.00 if you do not show up for the appointment or do not provide us at least a 24-hour notice to cancel your child's appointment. This applies to all specialty services offered at Pediatric Care Center (Enhanced Asthma Visits, Behavioral Pediatric Services and Pediatric Neurology Consultations).

Patient Name: _____ Date of Birth _____

Patient Name: _____ Date of Birth _____

Patient Name: _____ Date of Birth _____

Patient Name: _____ Date of Birth _____

Parent/Legal Guardian: _____ Date: _____

Thank you for upholding our financial policy. If you have any questions or concerns, please contact our billing department.