Financial Policy
Madison Pediatric Associates

Thank you for choosing Madison Pediatric Associates, PSC as your primary care provider. The following is a statement of our Financial Policy, which we require you to sign prior to any treatment. All patients / parents must complete this form prior to seeing the Pediatrician.

We are committed to providing excellent medical care at a fair and reasonable price. Our staff will be happy to discuss any fees or financial issues in advance or at the time of your visit. We will make every effort to work with you to file insurance claims and timely resolve any outstanding balances.

INSURANCE: Insurance coverage is a contract between you and your insurance company. Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered and not covered. If the insurance company has not processed and paid the claim within 90 days, then payment of the account will become the responsibility of the parent / legal guardian. In the event of a separation / divorce, the parent bringing the child for the appointment is responsible for payment.

DEMOGRAPHIC INFORMATION & INSURANCE CARDS: It is important that we have updated demographic data from both parents so that we will be able to contact you in the future. We also must have a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to Timely Filing requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for timely filing by your insurance and those claims would become your financial responsibility.

NETWORK PROVIDERS: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify if there is any question regarding network eligibility.

CO-PAYS, DEDUCTIBLES: I understand that any co-pays are due from me at time of service. If not paid at time of service, a $10.00 fee will apply. I understand that I am responsible for any balance not covered by my insurance.

CANCELLATION OF APPOINTMENTS: As a courtesy to other patients and physicians, we require an advance notice prior to cancelling appointments. There will be a $25.00 fee for failure to notify us in advance. After three no-show appointments, the patient will be released from the practice.

PAYMENT: We accept Cash, Check, Mastercard, Visa and Debit Cards.

Assignment of Benefits / Authorization: As a parent or legal guardian, I authorize payment of medical benefits to be made directly to Madison Pediatric Associates for services rendered. I further agree to be fully responsible for all lawful debts incurred for services provided.

➜ ☆ **Signature of Parent / Legal Guardian** ______________________ **Date** ______________