CONYERS PEDIATRICS

Conyers Pediatrics would like to take this opportunity to welcome new members to our practice and thank our returning patients. To avoid confusion regarding our current billing policy, please review the following and sign below. A copy will be provided for your records upon request.

1. Co-payments and balances are due prior to your child being seen and can be paid in person or through the Patient Portal. **A service fee may apply for any copayment not paid at the time of service.**
2. **If your child is seen for a wellness visit and also treated for a medical condition, your insurance carrier may process this visit with a copayment or coinsurance, for which you will be responsible.**
3. If you do not have insurance or are under insured, payment is due at the time of service.
4. Private paying patients are eligible for a discount if payment is made at the time of service.
5. All payment arrangements must be made with our Billing Department prior to your child being seen. If payment arrangements are allowed, it is your responsibility to submit payment within 30 days, whether or not you receive a statement.
6. You may only be sent three statements before we begin collection proceedings if payment arrangements are not made. All accounts sent to an outside agency for collections will be assessed up to a 30% collection fee and any self pay discounts will be added back to your account. A courtesy call to the last number we have on record will be made but is not necessary in order to forward an account to a collection agency. **Please note - once an account is sent to collections, your child may be discharged from Conyers Pediatrics.**
7. A $28.00 service fee will be charged for all returned checks relating to your child's account and any offered private pay discounts will be added back to your account.
8. **Be aware of your insurance plan!** We will attempt to verify coverage through the insurance company, though **it is not a guarantee of coverage**. Call your insurance carrier if you have any questions.
9. **Whomever brings your child to the office is responsible for any payment due related to that office visit**. This includes grandparents, babysitters and other caretakers. Please complete the Consent to Treat form specifically naming anyone other than a parent authorized to accompany your child to our office and giving us permission to release your child's medical information to this person. We will request a photo ID from each person bringing your child to our office to verify their identity.
10. No one under age 18 years will be treated without a parent or guardian (or authorized person over eighteen years old) present.
11. A copy of your insurance card should be provided at the time of service. If updated insurance information is not received by our Billing Department within your insurance plan's timely filing limit, the balance is parent/patient's responsibility. Please be advised - timely filing may be as little as 30 days.
12. We file your insurance as a courtesy. If payment is not received from your insurance company within 45 days, the balance is your responsibility.
13. If you are sent to a specialist and your insurance requires a referral, please contact the front office once you have the appointment scheduled. as we need to know the appointment date and time. Most insurance require at least 48 hours notice for a referral so please, do not wait to contact us the day of the appointment.
14. Please give our office 24 hours notice if you cannot make your child's appointment. If you do not give us at least **24 hours notice, a service fee of $25.00 will apply**.
15. A $10.00 fee will be applied for each form and/or letter, $25.00 fee for FMLA forms.

We appreciate your cooperation. Please let us know if you have any questions or need assistance. You can reach our Insurance and Billing Department at 770-922-5745.

I accept full financial responsibility for the above named child and acknowledge that by signing below, I have read and understand this billing policy. I acknowledge my payment options are through the secure Patient Portal, telephone, mail, or in office.

Upon my request, a copy of this policy has been provided for my records.

Patient Name_____ DOB_____

_____ _____

Signature/Relationship Date