# Our Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless arrangements have been made in advance. We accept Visa, MasterCard, Debit cards and cash.
2. Keep in mind that your insurance policy is basically a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to the doctor- in other words, if you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
3. We have made prior arrangements with many insurance companies and other health plans to accept an assignment of benefits. We will bill them, and you are required to pay a co-payment at the time of your visit. You will also be responsible for any co-insurance or any charges that may be applied to your deductible.
4. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you in an unassigned basis. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.
5. Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered," you will be responsible for the complete charge. Payment is due upon receipt from our office. Please let our office know if your insurance does not cover immunizations as we can enroll you in our New York State Vaccines for Children Program which offers vaccines at a reduced rate of $17.85 per vaccine.
6. Our policy is to charge $100.00 for missed well exams, and $40 for missed follow appointments without 24 hours notice of cancellation. If you need to cancel a sick visit, advanced notice is appreciated, however no fee will apply for cancellations.

I have read and understand Downtown Pediatrics' financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____

Signature of Patient (or responsible party, if minor) Date

I have also received a copy of Downtown Pediatrics' Notice of Privacy Practices.

_____

Signature of Patient (or responsible party, if minor) Date

_____

_____

_____

Please print the name of patients