Pediatric & Medical Associates PC

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325 South Main Street
Cheshire, CT 06410
203-271-1541
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Financial and Billing Policy Effective 1/1/2023

Pediatric and Medical Associates will submit claims to participating Insurance Plans. Co-payments, previous balance such as deductible, coinsurance and any services or items that are not covered by your insurance plan are collected at the time of service. We provide authorization to save credit card on file for copayments and previous balance.

For Newborns, please ensure to notify your insurance within 30 days of the birth date.

- The parent, guardian or accompanying adult is responsible to:

  1. Bring an updated insurance card to each office visit.
  2. Report all primary and secondary insurances at the time of service to bill insurance accordingly.
  3. Coordination of benefits and to designate our clinician as your child's Primary Care Physician if required by your insurance.
  4. Co-payments are due at the time of visit assigned by your insurance.
  5. Contacting your insurance company to confirm benefits for services rendered prior to the visit.

- Please be aware of additional office fees such as:

  1. $5 billing fee for any co-pays not paid at the time of visit.
  2. $40 fee for No Show appointment and cancelled appointment with less than 24-hour notice.
  3. $20 returned check fee.
  4. Fees for medical records requests in accordance with Connecticut State and Federal Laws at the time the request is made.
  5. $25 fee for initial FMLA forms and $10 fee for renewal forms.

- The following terms apply to unpaid balances:

  1. All accounts over 60 days past due are subject to be turned over to a collection's agency. Patient accounts turned over more than once are subject to dismissal from the practice.
  2. 1.5% interest will be added to balances over 60 days old.
  3. After two returned checks, cash or credit card payments will only be accepted.
  4. If you need assistance setting up a payment plan you may also contact our billing office.

Pediatric and Medical Associates offers a 20% discount to Self-Pay patients for the office visit only when paying in full at the time of visit.

Please sign and date below acknowledging your receipt of this policy. If you would like a copy of this policy, please advise the front desk staff.

I, the undersigned give my authorization to treat and assign directly to Pediatric and Medical Associates, PC (PMA) al medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for the payment of any deductible amounts, coinsurances, or other expenses not paid by my insurance, as well as any administrative costs such as missed appointments, rebilling fees, and expenses incurred in attempting to collect balances not paid at the time of service.

Signature: **Print Name:**	**Date:**	**Pediatric and Medical Associates, PC**