Children's Surgical Associates
Financial Policy/Office Consents

Patient Name: _____

Thank you for choosing Children's Surgical Associates for your child's care. In order for us to deliver a high quality of care, it is necessary to provide a financial policy. Please read all information and acknowledge by signing below.

1. A copy of your insurance card and a photo ID for the parent or guardian is required at all visits. In addition, the address on the photo ID must match what we have on file. If it does not, proof of residency will be required (i.e. copy of a utility/cable/phone bill). It is your responsibility to notify us of any changes in your personal or insurance information. Failure to do so will make you liable for denied claims.

2. Insurance eligibility will be verified prior to each visit. If your child is not eligible for insurance coverage, you will be responsible for payment in full at the time of service.

3. All patient balances including, but not limited to deductibles, coinsurances, & co-payments are due in full at the time of service. We will collect all balances according to the benefits received from your insurance company. At times, a claim may be processed differently when received by the insurance carrier. If this occurs, you will be responsible for any remaining balances, and any issues regarding your policy benefits must be addressed directly with your insurance carrier. **In addition, any amounts collected in the office are estimates and may change once physician documentation is reviewed. Any remaining balances will be your responsibility and billed to you directly.**

4. Our office accepts cash, checks, Visa, Mastercard, & Discover. We also offer Care Credit as a payment option, which our billing office will be happy to discuss with you. **Co-payment amounts are required by your insurance contract and cannot be billed to you.**

5. If your child requires surgery, any applicable deductibles, coinsurance amounts, or copays will be due in full one week prior to surgery. Estimates of the amounts will be provided to you. **These amounts are estimates and may change once a claim is submitted to your insurance company, or after physician documentation is reviewed.** In addition, you may receive bills from the hospital, anesthesia, pathology, etc. These bills are separate from our physicians' fees.

6. There will be a $30 fee on all returned checks.

7. **Out of Network PPO Plans:** If you have an insurance plan which our office does not participate with, we will file your claim as a courtesy; however any out of network benefits such as deductibles and coinsurances will be due in full at the time of service.

8. **HMO Policies**: If you have an HMO policy and your plan requires authorization, we will contact your PCP office to obtain this. If we are unable to obtain the authorization 24 hours prior to your office visit, we will need to reschedule the appointment. **We cannot obtain authorizations retroactively.**

9. **Self Pay Patients**: If you do not have insurance coverage, payment for all services will be due at the time of service.

10. **No Show & Missed Appointments**: As a courtesy to other patients, we ask for at least 24-hours notice for all cancellations. Any appointments cancelled with less notice will incur a **$25 cancellation fee**. In addition, any no-showed appointment will also incur a **$25 fee**. All fees must be paid in full prior to scheduling another appointment.

11. If an account becomes delinquent and is sent to an outside collection agency, any fees incurred as a result will be your responsibility and must be paid in full prior to scheduling another appointment.

12. I give consent for CSA to take photos of my child for the purpose of the medical record for treatment and/or educational purposes. In addition, if any photos, cards, letters, etc. are sent to the physicians or office, these may be displayed on a bulletin board in a public area of the office.

If you have any questions regarding this financial policy, please contact our Billing Manager or Practice Manager.

I have read and acknowledge the above Financial Policy of Children's Surgical Associates. I understand that Children's Surgical Associates will file claims to my insurance company as a courtesy, and that I am ultimately financially responsible for my child's account.

_____ _____/_____/_____

Signature of Parent or Legal Guardian Date