1780 Nicholasville Rd., Suite 301
Lexington, KY 40503
(859) 277-6636
www.cwpediatrics.com

FINANCIAL POLICY

It is our pleasure to be chosen as your pediatric primary care provider. At Commonwealth Pediatrics, PSC, it is our goal to help families raise healthy children. It is our main priority to provide you and your family with exceptional care and service. The following is a statement of our Financial Policy which serves as a clear understanding of your financial obligations. Should you have any questions regarding this policy, we encourage you to contact our business office. One of our billing representatives would be more than happy to discuss any financial matters with you.

Insurance: We participate with most major insurance companies. It is your responsibility to make sure that your pediatrician is participating with your individual health care policy. Your insurance plan is a contract between you and your insurance company. Therefore, it is your responsibility to know your eligibility, coverage, and benefits available to you under your insurance plan. If you are experiencing difficulties or delays with your insurance carrier or difficulties with payment of benefits under your insurance plan, we encourage you to contact the Consumer Protection and Education Division of the Kentucky Department of Insurance at (800) 595-6053. Questions about your specific insurance plan should be directed to your insurance provider. You are personally responsible for any balances not paid by your insurance company.

Demographic Information & Insurance Cards: It is very important that we have updated demographic information as well as a copy of your current insurance card at all times. It is your responsibility to notify us of any changes in insurance or changes to your individual insurance policy. This includes any new effective dates for your plan. Many insurance companies have strict time limits for filing claims. If we do not have your updated information, your claims may be denied for timely filing, and these balances will become your responsibility. Please make every effort to bring a copy of your child's insurance card to every appointment.

Co-Pays & Patient Balances: All co-pays and any outstanding patient balances are expected to be paid at the time of service. Any balance not paid by your insurance company is your responsibility.

Patients Without Insurance Coverage: For patients without insurance coverage, full payment for the services provided during your appointment is expected at the time of service.

Payment and Collection on Accounts: We accept cash, check, Visa, MasterCard, or Discover card as forms of payment. You may be contacted at any of your listed contact phone numbers in order to settle any outstanding balances. Delinquent accounts with outstanding balances greater than 90 days may be turned over to an outside collection agency. *Commonwealth Pediatrics, PSC reserves the right to dismiss patients with delinquent accounts.*

After Hours/Weekend Appointments: There may be an additional fee charged for appointments after our normal business hours, weekends, and holidays. Fees for these visits may or may not be covered by your insurance carrier. Please contact your insurance provider if you have questions about coverage for these appointments.

Returned Checks: There will be a $25.00 additional fee charged for any checks returned by your financial institution. After 10 days, any unpaid returned check will be sent to the Fayette County Attorney's Office.

No-Show/Cancellation of Appointments: We understand that sometimes life happens and you may not be able to make it to a scheduled appointment. As a courtesy to our providers, and other patients on our waiting list, we require a 24-hour advanced notice for cancellation of any scheduled appointment. Please call our office if you cannot make your appointment. Any patient who does not show for their scheduled appointment, or fails to provide proper advanced cancellation of a schedule appointment, may be charged a $50.00 no-show/cancellation fee. This fee will not be paid by your insurance company. *Commonwealth Pediatrics, PSC reserves the right to dismiss patients with excessive no-shows or improper advanced cancellations.*

_____ _____ _____

Signature of Parent/Legal Guardian/Guarantor Print Name Date

Patient(s) Name and DOB: _____