Patient Name_____ Account#_____

RIVIERA PEDIATRICS

Financial Payment Policy

Thank you for choosing Riviera Pediatrics as your child's primary care provider. Please read this payment policy and sign it in the space provided. We will provide a copy for your own records.

1. **Insurance Billing:** We participate in most insurance plans, including Medicaid. As a courtesy to you, we will file your claims to your insurance company. Remember, most secondary insurance claims are your responsibility to file. However, it is your responsibility to understand what services are covered under your medical insurance policy. If you have any questions whether a service is covered, we urge you to contact your insurance company before the service is provided. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Medicaid:** As per Indiana State Law, you are required to see the physician your child has been assigned to by Medicaid. You will be responsible for the balance if your child is ineligible for Medicaid benefits through our practice. We look forward to treating your child once you've been reassigned to one of our doctors.
3. **Copayments and Deductibles:** All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. At the time of check-in, each parent/guardian will be asked to make this payment. Because this is an insurance requirement, we cannot bill you for these.
4. **Non-covered services:** Please be aware that some or perhaps all of the services you receive may not be covered by your insurance. You must pay for these services in full at the time of your office visit.
5. **Proof of insurance:** All parents/guardians must complete our patient information form before seeing the doctor. It is your responsibility to provide us with the correct and current insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
6. **Claims of submission:** We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. If the claim is denied and/or remains unpaid, the balance on your account is your responsibility. After your claim has been filed and paid by your insurance company, you will be billed for the remainder of any balance. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
7. **Coverage changes:** If your insurance changes, it is your responsibility to notify us before your next visit so we can correctly file your claims to help you receive your maximum benefits. If not, you may incur further charges because of claims being filed to the wrong company.
8. **Nonpayment:** If your account is past due, you will receive a letter stating that you have 7 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with a payment plan. Please be aware that if a balance remains unpaid, we may refer your account to an attorney and be taken to small claims court. We could proceed with wages being garnished at that time. If your account becomes outstanding, you will be responsible for all costs of collection including, but not limited to filing fees, reasonable attorney fees, interest on any judgment obtained, and other like costs.
9. **Transferring of Records:** You will need to request in writing, and pay a service fee if you want to have copies of your records sent to another doctor or organization. The fee will be charged according to the number of pages and postage rate. You must authorize us to release this information.
10. **Returned Checks:** There is a $25.00 fee for any checks returned by the bank.

Note to divorced parents of dependents. Both parents are responsible for the dependent's fees unless documented with a court order/decree. We will send our statement to the address you have given us and the responsible party should make prompt payment upon receipt.

Please be sure to bring your current insurance cards with you at every visit so that we properly bill your correct and current insurance. By my signature below, I state that the above policy has been read and that I understand and agree to said policy.

Thank you for understand our payment policy.

Signature_____ Date_____