|  |  |
| --- | --- |
| **\\pawi-srv-02\User Documents\mnagel\Desktop\PAWI logo Sept2012.jpg** | **Pediatric Associates of Whidbey Island****275 SE Cabot Dr., Suite B102****Oak Harbor, WA 98277** |

**Financial Policy**

We would like to thank you for choosing *Pediatric Associates of Whidbey Island* as your child’s doctors. As one of our patients, we would like to keep you informed of our current office and financial policies. We require a signature to document that you have read and understand these policies.

**Payment**

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable co-payments for participating insurance companies, regardless of who brings the child in for the appointment. We accept cash, personal checks (in-state only), and all major credit cards. Proper identification is required.

Please note:

* There is a $25 service charge for returned checks.
* Patients who do not pay the co-pay at the time of service may incur a billing fee of $10.
* Patients who have an outstanding balance of 30 days may incur a rebilling fee of $10 per statement for administrative costs.
* Patients with an outstanding balance more than 90 days overdue must make arrangements for payment prior to scheduling appointments.
* Patients with an account sent to collections, must satisfy account balance prior to making any additional appointments.
* Parents are ultimately responsible for any charges or portion thereof for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

We realize that people have financial difficulty. Therefore, please stay in close communication with our billing department. Financial considerations should not prevent children from receiving the care they need at the time they need it.

We require our office registration form be updated **annually, or anytime there is a change in your contact information,** to ensure that we have the correct information for you. Incomplete or incorrect information can result in non-payment from your insurance.

Our billing department is available Monday-Friday 8:00am-5:00pm to assist you with any questions or payment arrangements. Please call (360) 675-5555 ext 13 or ext 10.

**Insurance**

It is the patient’s responsibility to provide us with current insurance information and to present an active insurance card at each visit. If there is a change in your insurance coverage, please notify our office as soon as possible.

If your plan requires, you must name *Pediatric Associates of Whidbey Island* as your primary care physician prior to your first appointment. If a *Pediatric Associates of Whidbey Island* physician is not named on your insurance as your primary care physician, your appointment will need to be rescheduled. It is the parent’s responsibility to contact your plan to update this information when needed.

**Missed Appointments, Late Arrivals, or Last Minute Cancellations:**

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for your child. If you are unable to keep an appointment, we require 2 hour notice of cancellations so we may utilize the time for another child. More than 3 missed appointments, last minute cancellations, and/or late arrivals in a 12 month period are considered excessive and may result in discharge from our practice. If you arrive more than 15 minutes late for appointments, you may be asked to reschedule your appointment. **We reserve the right to charge $20 for each non-cancelled appointment after a second appointment has been missed.**

**Unpaid Accounts**

If your account has been turned over to a collection agency, you will be responsible for all costs and expenses of collection including, but not limited to our reasonable attorneys’ fees.

Patient Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Signed