

The Carithers Pediatric Group

Financial Policy

We are committed to providing you with the best possible care and a clear understanding of our financial policy. If you have any questions concerning your responsibilities, please feel free to ask us. The billing department and/or office manager handle such matters, not the doctors. Please direct your questions accordingly.

Please follow the guidelines listed below:

You will be asked to present your child's insurance card at each visit so information can be updated and claims can be filed.

Full payment and old balances are expected at the time of service.

We accept most insurance plans; however you are responsible for any deductibles, coinsurance or co-pays at the time of service. The person who accompanies the child to the visit will be asked for payment that day. You are responsible for the bill in full if no payment is received from your insurance company. We cannot be held responsible for filing claims to the wrong insurance company which may create timely filing denials and payment denials. Please understand that if your insurance does not pay for a service, you will be responsible for payment in full. It is your responsibility to understand your plan benefits. You are responsible to notify the office of any insurance change. We will file and accept insurance payment from your primary insurance company only if we participate with your insurance plan. It is your responsibility to insure that we have a copy of your current insurance card on file. We do not file the insurance claims to or accept payment from insurance plans that we are not contracted with. We do not file auto insurance.

Settlements/financial responsibilities, such as divorce must be settled between the parents. We do not get involved with these issues. We are here to provide care for your children.

If you are self pay, please be prepared to pay in full at the time services are provided. We accept cash, personal checks, and Visa, MasterCard, American Express, Discover and debit cards.

A service charge of \$30 will be applied to all returned checks.

There will be a \$25 no show fee for all missed appointments not canceled within 24 hours.

If at anytime your account requires outside collection efforts, you will be responsible for your balance.

We thank you in advance for your understanding and cooperation. If you have any questions regarding our policy, please call our business office number (904) 387-9505.

I understand and agree that, regardless of my insurance status, I am responsible for my account. I have read all of the information on this sheet and understand it to the best of my ability.

Child's Name _____ **DOB** _____

Signature of Parent/Guardian _____ **Date** _____