

**PEDIATRICS WEST, P.C.**

**FINANCIAL POLICY**

Today’s Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

With the rising costs of healthcare, we are working to keep our costs down and avoid increasing our fees. We are updating our Financial Policy.

Please provide ALL insurance information for plans your children are covered on, including secondary insurance coverage. We are required to bill all insurance plans. If you fail to provide correct and up-to-date insurance information, you may be responsible for the full amount of your bill.

For the first 30 days for newborns, please provide both mom and dad’s coverage information. We are required by Colorado law to bill all insurance plans. You have 30 days to add newborns to the insurance plan.

**Co-Payments**

Commercial plans with established co-pays are due at the time of service.

**Deductible Plans**

Payment of $75.00 will be collected at time of service for sick visits. We will submit your claim to your insurance company and bill you for the remaining deductible amount once the claim has processed.

**Self-Pay Patients**

Patients without insurance will be provided a self-pay discount due at time of service.

**Parent/Guardian Responsibility**

It is your responsibility to verify that Pediatrics West accepts your insurance. Please bring your insurance card to all of your child’s visits and be prepared to pay any previous outstanding balance on your account. In the event that your health plan determines that a service is “not covered due to medical necessity,” you will be responsible for the charge.

There are also times when it is necessary for us to send lab work to an outside laboratory. While we do our best to let you know about this ahead of time, we are not responsible for any costs related to those tests, nor do we have any knowledge what those costs might be.

If this policy presents an undue hardship to your family now or at any time in the future, please feel free to discuss your situation with our billing staff (720-284-3717). We understand that everyone has troubles now and then, and we’re willing to help if we can.

Thank you for your cooperation.

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Responsible Party Name Signature

Child’s name Date of Birth

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*(for office use only) Patient (seen today) MRN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*