



Holliston Pediatric Group Financial Policy

Thank you for choosing Holliston Pediatric Group (HPG) as your child's health care provider. We appreciate the trust you are placing in us and ask that you read this financial policy statement thoroughly and sign the acknowledgement form.

Payment for Services

---**Our fees** for medical care are usual and customary for this area and vary with the type of service your child receives. While HPG is contracted with most of the major health insurance carriers, it is your responsibility to understand and comply with the terms of the contract between you and your insurance carrier (we are not part of that contract). Some of the services we provide may not be covered by your health insurance and payment for these services are ultimately your responsibility. We accept Visa, MasterCard, American Express and Discover.

--**If your** insurance coverage changes, it is your responsibility to notify HPG within 30 days. If we are unable to bill your insurance company because coverage information has not been provided in a timely fashion, these uncovered services would be your responsibility.

---**In order** to maintain accurate and up-to-date information about your health insurance information we ask that you bring your child's insurance card to each and every visit. For the health insurance plans we are contracted with we are required to bill them directly on your behalf. However, any copayments, deductibles and fees for non covered services are your responsibility. Per your contract with your insurance plan, copayments (if applicable) are due at the time of service (**there is an additional \$10.00 fee per child for any copayment not paid at the time of service**).

---**If HPG** is not contracted with your health insurance carrier, or you do not have health coverage, payment in full is due at the time of service. **For patients without insurance**, we offer a 25% discount for payment in full at the time of service (cash or credit cards only)

---**Payment** for any outstanding balance is due within 30 days of receiving a billing statement. Accounts with outstanding balances beyond 30 days are at risk of being forwarded to our collection agency. If you are experiencing a financial hardship, please contact our billing supervisor at 508 429-2801, ext 820. Our goal is to be considerate and understanding of such circumstances and work with you to resolve your outstanding balance.

Other Billing Issues

---**No shows** or cancellations with less than 24 hours notice for routine well exams follow up visits and consults (including visits with the nutritionist) will incur a charge of \$25.

---**Checks** returned by your bank will be assessed a \$35 returned check fee, as well as the original amount of the check. If the check is not replaced and the fee paid within 10 days, your account may be forwarded to our collection agency. Accounts with repeated returned checks will be required to pay by cash or credit card.

---**Newborns** need to be registered with your health insurance plan as soon as possible after birth. Failure to do so could jeopardize payment for services rendered.

---**Requests** for copies of medical records will be charged a fee in accordance with the regulations established by the Board of Registration in Medicine.

-- **We are** required by our contract with your insurance company to notify them of all services provided at your visit. This is done by including services on our claim forms. Your contract with your insurance company determines whether a co-pay, co-insurance, or a deductible is due for services rendered.

--**Most insurance** companies do not require a co-payment for a well child visit. However, any acute illnesses discovered during a visit or a comprehensive review of any chronic diagnosis may generate a co-payment. Your contract with your insurance company determines if a co-payment will apply.