Financial Policy

Welcome to our office and thank you for choosing Pediatric Gastroenterology Associates for your care. Our goal is to provide you with the highest medical care. We have developed this financial policy because we believe your clear understanding of our policy is very important to our professional relationship.

It is your responsibility to know the limits and coverage of your particular health insurance policy and to show your cards to us at each visit. We will make clinical recommendations that we think are in your best interest, but we cannot guarantee that your policy will cover any and all charges incurred**. If you have a co-pay, it is expected to be paid at the time of service**. If you are unable to comply, a billing surcharge will be added to your account. We participate with most major insurances. If we do not participate with yours, we expect payment at the time of service. We will be happy to file your claim for services if you have given us all the required and correct information. Regardless of participation, we will not become involved in disputes between you and your insurance company regarding deductibles, co-pays, covered/non-covered charges, etc. other than to provide factual information necessary. If both parents carry health insurance for the patient, please check your insurance companies to determine which policy is primary prior to your appointment. If you have any questions regarding payments allowance by your insurance company, our billing team will be happy to discuss it with you.

If there is a balance on your account, a billing statement will be sent to you monthly. Payment is due in full upon receipt of the billing statement. A $5.00 rebilling fee will be assessed for each additional billing statement that is necessary until your balance is paid in full. If your account becomes 90 days delinquent, we will begin collection proceedings and a 33% additional fee will be added to your account to cover collections cost and your protected health information may be disclosed during collections proceedings. To avoid collections, you may set up an approved budget plan with our billing office. We accept cash, personal checks and all major credit/debit cards. If your personal check is returned unpaid from your bank, a $30 returned check fee will be added to your account.

For missed appointments, a missed appointment fee of $50 will be charged to your account. The parent/legal guardian/authorized adult accompanying the minor/child are responsible for payments, regardless of legal or custodian arrangements. We do not get involved in financial disputes between parents; the parent who brings the patient for services is expected to pay co-pays and non-covered services at the time of service. Subsequently, bills will be sent to the address of the record and the patient who lives at the address will be responsible for payment.

I have read the Pediatric Gastroenterology Associates financial policy and agreed to its terms. I understand that I am financially responsible for all charges whether or not covered by my insurance. I authorize the release of any other information necessary to process our claims and I irrevocably assign Pediatric Gastroenterology Associates payment for services rendered.

Signature of Parent/Legal Guardian _____ _____