PATIENT FINANCIAL POLICY

In compliance with the Federal Consumer Protection Act, GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC wishes to notify you of our policies regarding the financial responsibilities associated with services rendered to your child. Acknowledgement of this policy is required to receive treatment.

Insurance

It is your responsibility to familiarize yourself with the details of your insurance policy. It is your responsibility to confirm with your insurance carrier that GROW is considered to be "in-network" with your specific plan. Please refer to the Member Services phone number on your ID card.
As a courtesy, we will bill your insurance company, provided we have the correct billing information at the time of service. If a claim is denied because you have not provided correct and active insurance details, the charges will transfer to your responsibility. As a courtesy, we will provide to you any information we have acquired requiring your specific benefits, and your estimated cost. Co-Pays are required to be paid at the time of service. ***You are financially responsible for charges deemed by the insurance company to be billable to the patient.*** You must be familiar with your particular coverage and any requirements for pre-authorization, deductibles, and limitations on well child visits, lab services, immunizations, and other procedures.

Self-Pay Account

If proof of insurance is not provided, your account will be considered a self-pay account and payment in full of all charges will be required at the time of service. In accordance with the No Surprises Act of 2022, you will be provided with a Good Faith Estimate from GROW prior to your appointment, provided that the appointment is scheduled 2 or more business days prior to the date of service. If you subsequently provide verifiable insurance information, ***and the time frame for billing the insurance has not expired*** (generally 45-90 days), we will bill the charges to your insurance company for you. If we then receive insurance payment, we will promptly issue a refund to you of any credit on your account.

Billing

The billing statement you receive will show patient balances due, in addition to insurance company payments, adjustments, and pending amounts. Patient balances are due from you upon receipt of the statement. Balances can be paid online on the GROW Intelichart Patient Portal (link can be found on our website) or by calling our office directly and choosing the option for the Front Desk. Accounts left outstanding with no good faith effort to resolve the balance will be sent to National Healthcare Collections, LLC. Once a patient account is in collections,

GROW cannot take payment toward the balance in question. To arrange payment with NHC, please contact them at (877) 313-4138.

Appointments

Please remember that your appointment time is reserved just for you. Our schedules are full each day and we must leave enough room in our schedule to bring in sick children on the same day. If your appointment is missed or cancelled with less than 24 hours' notice, consider that another child could have been seen at that time. We reserve the right to charge a $50 cancellation or 'no show' fee, beginning with your family's second occurrence. In order to see each patient on time, it is our policy that your appointment will likely be rescheduled if you arrive more than 15 minutes late.

After Hours Phone Calls

Our office hours are Monday-Friday 8:00am-5:00pm. To utilize our After Hours nurse triage, please call our main number and follow the appropriate prompts. There is a $25 charge that will be billed to you for this service. Our triage service does have access to an on-call physician for urgent matters regarding such attention.

Saturday Visits

We charge an after-hours fee for physician visits held after regular business hours, such as Saturday clinic visits. This fee is $40 and is paid out of pocket, as it's generally not covered by insurance carriers.

Returned Checks

There is a $25 returned check fee in the event a personal check is returned to us for any reason.

ASSIGNMENT OF BENEFITS/MEDICAL RELEASE AUTHORIZATION

I authorize the release of any medical or other information necessary to process my child's insurance claim. I authorize payment of medical benefits to GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC for services rendered and agree to abide to the above noted financial policy. My signature below also acknowledges my understanding and agreement to comply with this Financial Policy, as stated.

_____ _____

Parent/Guardian Signature Date

_____ _____

Patient Name Date of Birth

Updated 01/2024