Branford Pediatrics
& Adolescent Medicine

784 E. Main St. Branford, CT 06405 203-481-7008 Fax 203-483-8786 CT Lab Lic# CL-0858
Patrick Alvino, MD Martin Gad, MD Christine Kennedy, MD Sherlet Kurian, MD
Pamela Murtagh, MD Erin Rice, MD Michael Sheehan, MD Elizabeth Perrone-Gray, APRN

FINANCIAL POLICIES

Initial____**INSURANCE PLANS:** I understand that my enrollment in my insurance plan is a contract I have with the carrier and not with the practice. Decisions about coverage are determined by the carrier. I understand that it is my responsibility to know my insurance benefits, including in-network vs. out-of-network coverage, and to know that Branford Pediatrics & Adolescent Medicine is participating with my plan. **Any questions about medical, well baby/preventive care, labs/x-rays and immunization coverage should be directed to my insurance carrier prior to my visits.** In particular, not all insurance plans cover specific lab tests, hearing, vision or development screens, or may only allow partial coverage. I understand that coverage for services varies greatly amongst insurance plans, and I must keep current with these specifics. I understand I have a right of refusal for any service or procedure.

Initial____**INSURANCE CARD:** I understand that presenting my insurance card at each visit, if requested, is my responsibility. If I have changed insurance carriers, **or carry secondary insurance,** it is my responsibility to alert the practice of either of these circumstances. I agree to pay any uncovered charges that result from not presenting accurate information at the time of the visit. I understand that any false misrepresentation of insurance coverage can lead to dismissal from the practice.

Initial____**COPAYS, DEDUCTIBLES, SELF PAY:** I understand that it is my responsibility to know my current copay. I agree to be responsible for all copays, deductibles and non-covered services determined by my insurance plan. If I do not have insurance coverage at the time of services rendered, I understand that FULL payment is due at the time of service.

Initial____**COMBINED VISITS:** I understand that at well child exams, if other health concerns are brought up that would typically require a sick visit, my insurance company may consider these two separate visits and require a copay and bill other charges accordingly.

Initial____**PAYMENTS:** I will promptly pay all amounts that have been determined my responsibility by my insurance carrier upon receipt of my statement. If I need help in setting up a payment plan, I will contact the business office, knowing that payment plans must be strictly adhered to. If I do not pay my bill, or have not kept current with my payment plan, the practice may ask for the assistance of an outside collection agency. **If my account is turned over to a collection agency, my relationship with Branford Pediatrics & Adolescent Medicine will be terminated and I will be subject to all associated collection fees. I understand that the business office is available to me to work out financial arrangements.**

Initial____**CHECK IN:** I agree to pay copays and past due balances at the time of Check In. If I defer payment of my copay, I understand that I will be assessed a $15 copay fee. The practice is willing to waive this if I call the business office with copay payment <u>on the date of my visit.</u>

Initial____**NO SHOWS:** I understand it is my responsibility to give the practice sufficient notice (within 24 hours prior) if I cannot keep my appointment. Other patients lose the opportunity to be seen when a No Show occurs—I may be subject to a No Show fee of $50 if I do not alert the practice appropriately that I no longer need the visit. I understand that 3 no show appointments in a calendar year, of any type of visit, may be cause for dismissal from the practice.

Initial____**REFERRALS and PRE-AUTHORIZATION:** I understand it is my responsibility to know if a written referral or pre-authorization is required for any specialists or procedures to which I am referred and to know what services are covered.

Initial____**AUTO/WORKERS COMP:** I understand that Branford Pediatrics & Adolescent Medicine does not bill auto insurance companies for visits and medical care related to auto accidents and does not participate in Workers Compensation claims. The business office will help me by reviewing any insurance/payment requirements before making my appointment related to an auto accident.

I have read, understood and agree to the above financial policies. v 5/21

Patient Name_____ Date of Birth_____
(Please Print)

Patient, Parent or Guardian Name_____ Date of Birth_____
(Please Print)

Patient, Parent or Guardian's Signature_____Date_____