Integrative Developmental and Behavioral Pediatrics, LLC

FINANCIAL POLICY – for New Patients

We believe that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

1. PAYMENT: Payment in full is expected at the time of your visit. We will accept cash, check, or credit card. We require that a credit card be kept on file for the convenience of payment for services not provided in person (for example, video calls, telephone and email consultation, medical forms completion, missed appointments.)

2. INSURANCE : We are not participating providers with any insurance plans (which means we are "out of network" for all insurances.) We will provide you with a "Superbill" for services provided, which you may then submit to your insurance company for reimbursement. Please keep in mind that insurance does not usually reimburse for email and telephone consultation, sometimes does not reimburse for video appointments, and that prolonged service (more than 40 minutes for a follow-up visit and more than 60 minutes for a new patient visit) is sometimes not reimbursed by insurance.

3. RETURNED CHECKS will incur a $30.00 service charge and may be reported to collections. Stop payments constitute a breach of payment and are also subject to the $30 service fee and collections action.

6. FORMS FEES: We may require pre-payment for completing forms, copying medical records, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus any applicable postage or notary fees. Copying fees for Medical Records are $10 for the first twenty (20) pages and $0.50 per page in excess of twenty. Please allow up to 15 business days for receipt of medical records.

7. CANCELLATIONS OR MISSED APPOINTMENTS: If you do not cancel your appointment at least 24 hours before, or if you no-show, your credit card may be charged the full appointment amount.

8. PAYMENT ARRANGEMENTS / CREDIT: Integrative Developmental and Behavioral Pediatrics, LLC does not make payment arrangements or extend credit. All services are expected to be paid in full at the time of service.

9. COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

10. DIVORCED PARENTS of PATIENTS: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about any treatment and/or payment issues.

Initials________Date________ Patient name_________________________________

11. APPOINTMENT/CONSULTATION FEES: Appointment charges are based on duration of appointment (most follow-up visits will be 40 minutes):

60 minute new patient appointment: $480

40 minute follow-up visit: $320

25 minute follow-up visit: $200

Visits lasting more than 60 minutes for a first-time visit, or 40 minutes for a follow-up visit, will incur additional charges, which will be calculated in 15 minute increments (in addition to the 60 or 40 minute appointment charge, there will be a $120 charge for each 15 minutes of additional time spent)

Video/telemedicine appointments will be charged at the same rate as in-office visits. Please be aware that insurance does not always reimburse for video appointments/telemedicine

Phone calls and email communication may be subject to charges based on amount of time spent ($120 for each 15 minute increment of time spent). Please be aware that insurance does not usually reimburse for phone call or email communication.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time and I may request updated copies of the practice's financial Policy.

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Signature of Parent/Guardian/Guarantor Date

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Patient Name Date of Birth