

**Wee Care Pediatrics Group PLLC**

**Payment Policy**

**Effective January 1, 2009**

Thank you for choosing Wee Care Pediatrics to care for your family.

1. We ask new patients to be prepared to pay their co-payments and unmet deductible at the time of their visit. Patients with a set co-pay will be required to make the co-payment **PRIOR** to services being rendered.
2. Co-pays not made prior to your child's visit will be subject to a **service fee of \$15.00 per month**, each month it is not paid.
3. Payment of patients' responsibility **MUST NOT** be withheld or delayed due to pending insurance coverage in claims (co-pays, uncovered visits, etc.)
4. As a courtesy to our patients, we will bill your insurance for you, however, final responsibility for the bill remains with the patient or parent of a minor child. It is your responsibility to know if your insurance company covers well-child visits and /or immunizations.
5. **Payment solely rests on the person that signs this Billing Policy.** We request to make a copy of your drivers license so that we can protect your child and help avoid insurance fraud. We will not and can not be involved in divorce or separation issues. It is your responsibility to pay for accrued expenses and work out the financial arrangements with the other parties involved.
6. We ask that **after hour phone** calls are limited to new illnesses and immediate concerns. Prescription refills, well child questions and ongoing problems should be addressed during routine office hours. It is our policy that antibiotics will not be called in except in very limited circumstances. For all after hour calls that are inappropriate, there will be a \$6.00 charge. This is a charge to off set the cost of after hour coverage. It is not billable to any Insurance company or to Medicaid.
7. If you have any **concerns regarding your bill** please contact Kim at 304-399-5437. The physicians do not handle billing concerns.
8. **All returned checks are subject to a \$30.00 service charge.** Payment for the returned check and fee will need to be made in cash, money order or by credit card. A check will not be acceptable in this instance.
9. We appreciate your help and courtesy of a call if you are unable to keep an appointment or will be late. Please notify our office at least 24 hours prior to appointment time if you need to cancel or reschedule. If you will be more than 15 minutes late, your appointment may need to be rescheduled. If you do not notify us in a timely manner, we reserve the right to charge you a missed appointment fee of **\$30** and three non-cancelled missed appointments are **grounds for discharge from our practice.**
10. Any family sent to collections will be responsible for all collections fees. If a patient is taken to small claims court the patient will be responsible for all fees/charges.
11. You need to assign benefits/payments for your insurance payments to come to the doctor. You are also required to change PAAS providers to Wee Care if you have Medicaid with a PAAS provider.
12. A parent or legal guardian must accompany a child at their first visit. **This accompanying adult (who consents to treatment) is responsible for payment of the account,** according to the policy outlined here.

13. I authorize my insurance benefits be paid directly to Wee Care Pediatrics Group PLLC.
14. It is the responsibility of the parent or guardian to provide any insurance or medical card at each visit and to provide accurate and up to date address and phone number. We reserve the right to reschedule any appointment if you do not have an insurance or Medicaid card at the time of visit. The only exceptions are new babies that may not have gotten their first insurance or medical card.
15. I authorize Wee Care Pediatrics Group PLLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.
16. Payment for all services will be delinquent if not received by 60 days after we receive all of your insurance payments. Any balance beyond this time will be charged interest of 12% per month.

**I HAVE READ AND UNDERSTAND AND WILL COMPLY WITH THE ABOVE.**

**SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_**  
**(PATIENT OR RESPONSIBLE PARTY)**