



DESERT RIDGE CHILDREN'S CENTER

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Fax:



Financial Policy Agreement

Thank you for choosing Desert Ridge Children's Center for your child's medical needs. We are committed to providing you with quality and affordable health care. Because some of our parents/patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and initial/sign in the spaces provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans. If you are not insured by a plan we contract with, payment in full is expected at each visit. If you are insured by a plan that we accept, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing and understanding your insurance benefits is your responsibility.** Please contact your insurance company with any questions you may have regarding your coverage. **Initials** _____

2. Primary Care Physician Selection. Please be aware that your insurance may require you to select a Primary Care Physician (PCP). This must be done directly by the parent/patient **before** you are seen in our office. Please contact your insurance company directly to select our office as your PCP. Failure to do so will result in the insurance claim not being paid. The balance will automatically be billed to you. **Initials** _____

3. Newborns. All newborns must be added to the parent/guardians policy **before** being seen in our office, **within 30 days of birth.** Please contact your insurance company directly to make this addition. If newborn/child is not added to your policy the balance will become your responsibility. Payment will be expected in full. **Initials** _____

4. Co-payments and deductibles. All co-payments and previous balances must be paid at the time of service. This arrangement is part of your contract with your insurance company. **Initials** _____

5. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. It is your responsibility to know what is covered under your policy. The balance will automatically be billed to you. **Initials** _____

6. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your **driver's license and current valid insurance** to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. **Initials** _____

7. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. **Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.** **Initials** _____

8. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. You are responsible for services not covered by your insurance company. **Initials** _____

9. For returned checks we will charge you \$ 40 Service Charge. **Initials** _____

10. Non-payment. If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise approved by our office and a written and signed payment plan is completed. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis. **Initials** _____

11. Missed appointments. Our policy is to charge a **\$45 fee for missed appointments** not canceled within 24 hours before scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment. **Initials** _____

12. We charge \$25 for Medical record services like Transfer of Records, FMLA paperwork or Specialty Letters.

Desert Ridge Children's Center is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area and specialty. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

Signature of patient or responsible party

Date