Brentwood Pediatrics, PC

Financial Policy

Our providers strongly agree with the American Academy of Pediatrics recommendations that your child should receive regularly scheduled checkups. These visits may include routine labs, developmental surveys and the testing of hearing and vision. Not all insurance companies pay for these services. It is up to you to know your insurance plan coverage. We always suggest you check with your insurer or HR department BEFORE coming to the doctor to see what services are covered by the patient's insurance plan.

We have outlined our financial policy so that patients will better understand the billing process:

Brentwood Pediatrics, PC will:

- Verify eligibility prior to your appointment; however, this is not a guarantee of payment from your insurance company
- File insurance claims on your behalf in a timely manner
- Issue statements to you once insurance has made payment for services
- Accept payment in the form of cash, credit or check (Return check fee: $25)
- Arrange payment plans when necessary through the billing department
- Offer early walk in and weekend hours. There is an additional fee of $10.00 for this service that some insurance companies will not pay for

Your responsibilities will be to:

- Provide us with the most recent demographic and insurance information
- Notify us of any changes in your insurance status or insurance company
- Pay your Co-payment at the time of service
- Bring any school or sport forms that are required to be filled out by our physician. If they are needed after the office visit, there may be a separate charge that you will be responsible for.
- Pay any outstanding balance which is unpaid or denied by your insurance company
- Call your insurance company at our request due to a denial or to expedite payment

We at Brentwood Pediatrics care about your child's health. Please remember we file insurance as a courtesy to you. You, not the insurance carrier, are ultimately responsible for any unpaid fees.

Your signature below verifies you have read and understand our billing policy.

_____	_____	_____
Patient's name	Signature of Legal Guardian	Date