Rainbow Pediatrics
413.241.6152

Rainbow Pediatrics Financial Policy

Patient Name _____ **Patient Date of Birth** _____

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE WE DO NOT BILL SECONDARY INSURANCE COMPANIES

Rainbow Pediatrics is committed to providing you with the best possible care and will be pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important for our professional relationship. Please ask if you have any questions regarding our fees, financial policy or your responsibility. We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

It is your responsibility to have your most current insurance details with you. You will be asked for your card and applicable co-payments. If your insurance has changed, please obtain the expiration date of your old policy and the effective date of the new coverage, prior to your appointment. If this information is not provided or your insurance is inactive on the day of service, you will be expected to pay before being seen.

Rainbow pediatrics accepts cash, personal check, VISA, MasterCard, and Discover. There is a service charge for returned checks. Patients with an outstanding balance 30 days overdue must make arrangements for payments prior to scheduling appointments or Rainbow Pediatrics will decline to see the patient.

The outstanding balance must be paid within 30 days of receiving statement from Rainbow Pediatrics. Rainbow Pediatrics will decline to see patients with outstanding balances.

INSURANCES

If we have not received payment from your insurance company within 45 days of the date of service, you will be expected to pay the balance in full. You are responsible for all charges.

COMMERCIAL INSURANCE

We bill participating insurance companies as a courtesy to you. If you are covered by a commercial insurance carrier that we accept, we will file a claim to your carrier. **You must pay any Co-pay, Co-insurance or any deductible at the time service is rendered.** If you are a member of any other insurance carrier that we do not accept, you are expected to pay in full at the time service is rendered, and we will provide you with the necessary forms to file a claim with your insurance for reimbursement.

MEDICAID

We bill participating insurance companies as a courtesy to you. We accept Medicaid assignments. Rainbow Pediatrics does adhere to the Massachusetts Medicaid Agreement and Title 42 code of the federal regulation 447.20 and Civil Rights Act of 1964.

SELF PAY

Full payment is due at the time service is rendered. We accept cash, credit cards and debit cards. We try to make our fees reasonable and affordable if you are without insurance at the time of your visit. If you become eligible for insurance coverage after you have already paid for an appointment we will not be able to file your insurance. However, we will be happy to provide you with the necessary forms to file a claim with your insurance for reimbursement.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

WALK IN PATIENTS

If you are not a patient of Rainbow Pediatrics and want to be seen, e.g. vacationer or out of town guest, you must pay in full for the visit. You will be given a time of service receipt to submit a claim to your insurance company.

MISSED APPOINTMENTS / LATE CANCELLATIONS

Broken appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late-to-cancel appointments. Excessive abuse of scheduled appointments may result in discharge from the practice. **MORE THEN 3 NO SHOWS FOR PHYSICAL APPOINTMENTS WILL RESULT IN TERMINATION FROM** Rainbow Pediatrics. Rainbow Pediatrics reserves the right to terminate patients who do not follow medical advice given by doctor and do not show up for follow up appointments.

AGREEMENT

In consideration of the services rendered to me by my physician, I agree to pay all charges incurred as a result of such services. If all or part of my charges are payable by a third party reimburse, I understand that it is my responsibility to contact such third party payer and to arrange for payment.

I agree that should the amount for insurance benefit be insufficient to cover the expenses, I will be responsible for payment of the difference. I will be responsible for the entire amount due (excluding disallowed amounts per a managed care contract) for services rendered if the expense is not covered under my policy. I understand that Rainbow Pediatrics will not become involved in disputes between me and my insurance company regarding deductfbles, co-payments, covered charges and/or usual and customary charges other than to supply factual information as necessary.

All fees are due and payable upon billing. The undersigned will pay all costs and expenses including collection fees and attorney fees 'incurred or paid by Rainbow Pediatrics in the collection of this obligation by suit or otherwise.

This agreement shall remain in effect until revoked by me in writing. I also permit Rainbow Pediatrics to use photocopies of these agreements in place of the originals on file at Rainbow Pediatrics. Please let us know if you have any questions or concerns.

I have read and understand Rainbow Pediatrics Privacy and Financial Policy

_____ _____

(Signature of Responsible Party/ Guarantor) (Date)

Consent for Treatment

I hereby consent to medical treatment at Rainbow Pediatrics, LLC by its Doctor, Nurse Practitioner and other Staff.

_____ _____

(Signature of Responsible Party/ Guarantor) (Date)