CHILD HEALTH PARTNERS

1515 Lake Lansing Road Suite C-2 * Lansing, MI 48912

FINANCIAL POLICY

Welcome to our office! Communication is essential to all of us, so we would like to clarify our billing policies in order to provide you the best possible care.

Our current professional fees for services are:

Office Visits:	$ 88.00 - $175.00
Well Child; Birth to 11 years	$170.00 - $210.00
Immunizations 2 months-4 years	$550.00 - $700.00
Ear Rechecks, Weight Checks	$ 55.00 - $ 88.00

We participate with many of the area health plans and will file an insurance claim for the services we provide. An itemized receipt will be provided for you to submit to your non-participating insurance carrier. A receipt for cash, check, or credit card payments will also be provided.

1. **Payment, including your co-pay, is expected at the time of service. It is our policy that the parent presenting the child for treatment is responsible for payment.** In the case of divorce, payment is expected at the time of service and reconciliation is between the parents privately. VISA, MasterCard and Discover are accepted as well as cash, check or money order. **Initial____**

2. It is your **responsibility** to present your insurance card at every visit. If you are enrolled with any Managed Care Insurance plan, requiring a primary care physician, including Medicaid, it is **your responsibility** to make sure one of our physicians is listed as the primary care physician. If one of them is not listed as the primary physician and there is no referral to us, **your child may not be seen that day. Initial____**

3. Our office participates with many, but not all, insurance plans. Those we participate with are: PHP, SPHN, BCBS, BCN, BCBS PPO, Community Blue, PHP Medicaid, MICHILD, and some additional commercial carriers. It is **your responsibility** to check your insurance company's participating provider list to make sure that our office is listed as a participating provider. **Initial____**

4. If your Blue Cross and Blue Shield policy is Master Medical BCBS, **you will be responsible** to pay for the office visit at the time of service because Blue Cross will pay the benefit directly to you. **Initial____**

5. It is **your responsibility** to understand the benefits of your insurance policy. Please check with your employer regarding **office coverage, lab/culture coverage and immunization coverage.** **Initial____**

6. Please bring all insurance cards with you for the office visit. Advise us of any changes in your address, home and work phone numbers. **Initial____**

7. Remember, **you must notify** your employer within 30 days of the birth of your new baby to be added to your insurance policy. **Initial____**

8. There is a **$35.00 charge for missed appointments** not cancelled within 24 hours. I understand I am responsible for this fee. I understand it cannot be billed to my insurance plan. **Initial____**

9. There is a **$10.00 charge for copying and/or transferring** records to another practice. **Initial____**

10. Child Health Partners reserves the right to turn any account over to collections if it is deemed that the account has been in default of payment or compliance with this policy. **Initial ____**

11. Our office **sends labs/cultures to Sparrow Regional Laboratories. It is your responsibility** to let us know if your insurance Requires you to **have any lab work or culture sent to another carrier.** **Initial ____**

12. If my physician does not participate with my insurance company, or if my insurance company has not paid the claim within 45 days, I understand **that balance becomes my responsibility** and I must pursue reimbursement directly from my insurance company. If there is a balance on my account, a statement of my charges and payments will be sent to my mailing address. **Initial ____**

DATE: _____ **PARENTS SIGNATURE:** _____

PATIENTS NAME: _____ **D.O.B.:** _____

REVISED 1-15-16