Financial Policy

Greenwich Pediatric Associates aims to deliver the highest quality care to our patients. The following policies are enacted to allow us to complete this mission and avoid any misunderstandings regarding payment for professional services.

(1) Services:

a. At preventative visits, we follow AAP guidelines to provide your child with high quality care that may include screenings, vaccinations, and routine counseling. These services are usually covered under your insurance plan.

b. While we will try to address any of you or your child's concerns at these visits, there may be times when we ask you to schedule an additional visit so we may adequately address the problem. If extra services are rendered at your child's well-visit, such as addressing a new problem or non-preventative issue, or excess time is spent addressing your child's needs, we will need to bill you as such. In these cases, you may be charged a copay, and/or a deductible may apply in accordance with your insurance company's policy. You are responsible for these charges as they are a contractual agreement between you and your insurance company, and are not office policies. Please contact your insurance company prior to the rendering of services if you have concerns.

(2) Copayments and Deductibles:

a. We participate in most major insurance plans. Please see our list of participating plans. If you do not participate in one of these plans or do not have insurance, please let us know so that we may provide you with a cost estimate for our services.

b. Prior to any appointments, please ensure your insurance is active. Please bring your insurance card to all appointments and update us at check-in if your insurance information has changed. If you are sending your child with another caretaker, please make sure they have a copy of your current insurance card as well as written permission to accompany a minor (this form can be found on our website). Additionally, remember to enroll your newborn in a plan before day 30 of life.

c. We code and bill for services in accordance with the law and insurance code. Insurance company contracts determine copays, coinsurance and deductibles, and require that we collect from our patients that cost-sharing component. Not all services are covered benefits in all contracts. As every insurance company is different, please contact your insurance company with any questions regarding your benefits and payment obligations for different services. You are responsible for knowing what is and is not covered under your plan.

d. All families and patients must pay any and all fees due and payable at the time services are rendered. Copays are due at the time of service. If someone else accompanies your child to their visit, please ensure they are prepared to make payment.

(2) Forms of Payment:

a. We accept Visa and Mastercard. Amex will be accepted for form payments only.

b. Returned check fees will be charged at the bank rate.

(3) Cancellation and Late Fees:

a. Please make your best effort to be on time for appointments. If you need to cancel, do so no less than 24 hours prior to your appointment. If you are unable to notify our office >24 hours prior or do not show up for your appointment, you will be charged a $50 cancellation fee for a sick visit and a $75 cancellation fee for a well child visit.

b. Patients who show up greater than 15 minutes after their appointment time may not be able to be seen and may incur a cancellation fee. We will do our best to accommodate you in extenuating circumstances if our schedule allows.

(4) Form Fees:

a. There is a $25 form fee per form, or $60 annual fee per patient, with a family maximum of $225 for form completion. Our form year runs the calendar year of January 1 to December 31. Please allow 7 business days for completion of forms. If you need your form completed in an expedited manner, we may charge $50. For unique or complex forms, we may also charge an additional fee for our time. Our staff and providers spend significant time ensuring your child's forms are completed thoroughly in a timely manner. This time and service is not covered by insurance. Please remember, we do not keep copies of completed forms.

Please sign below to acknowledge you have read and understand this policy:

Name: _____ Date: _____

Signature: _____

Child(ren)'s name and DOB:

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