SANDHILLS PEDIATRICS - PATIENT FINANCIAL POLICY

Main Office	Dutch Fork Office	Northeast Office	Lexington Office	West Columbia Office
1749 Marshall St	7941 Broad River Rd	110 Summit Centre Dr.	4568 Sunset Blvd.	101 Sum Mor Drive
Columbia, SC 29203	Irmo, SC 29063	Columbia, SC 29229	Lexington, SC 29072	W. Columbia, SC 29169
(803)252-1801	(803)407-0704	(803)744-9000	(803)520-5144	(803)796-9200

We are dedicated to providing you with the best possible care and service, and believe understanding our financial policy an essential element of your care and treatment. **Payment is required at time-of-service.** All copays must be paid at the time of service and payment on any patient balance is required at check-in. I understand that failure to pay the copay at time of service will result in a billing fee. We accept cash, check, Discover, Visa, MC and American Express.

To make health care more affordable for our patients that do not have health insurance, Sandhills Pediatrics is willing to give you an adjustment on your office visit charge equivalent to the average adjustment of all of our insurance providers. We will adjust your office visit by 35% provided you pay in full at the time of service. If you do not pay at the time of service, the adjustment will NOT be applied and you will be billed for the entire amount. We hope this offer will make health care more affordable to you.

REGARDING INSURANCE: By providing your insurance information, you have asked, and promised, to pay for services we provided with this information. Your insurance policy is a contract between you and your insurance company and we are not a party to that contract. Please know your benefits, limitations, and responsibilities of your plan. Your balance is your responsibility.

We participate with many health plans. We will bill those plans we have a contract with and will collect any required co-payment at the time-of-service. If your health plan determines a service to be "not covered", or you provided incorrect or late insurance information, you will be responsible for the complete charge. If this happens, we will bill you and payment is due upon receipt of that statement. If you have insurance with a plan that we do not have a contract with, we require full payment at the time-of service. Please understand that you hereby assign your insurance benefits to Sandhills Pediatrics and it is your responsibility to contact the Billing Department at 803-788-6146 with any questions or disputes about your bill.

Regardless of any insurance company's arbitrary determination of usual and customary rates, or denial of coverage, you are responsible for payment. If you have a HSA/HRA, we require payment at time-of-service. We will provide all documentation and receipts necessary so you can be reimbursed by your account(s). Fraud laws prohibit us from changing your procedure and/or diagnosis codes "just to get your claim paid". We make every effort to code and file claims accurately according to the services rendered and your doctor's documentation.

OVERDUE PAYMENTS: Payment is "overdue" when a balance exceeds 30 days from the date-of-service. If your account is sent to a collection agency, the collection agency's fees, and any associated legal fees, will be added to your account.

MISSED APPOINTMENTS: I agree to be on time for my appointments and will pay a missed appointment fee for any appointment I miss or if I fail to notify the office at least 8 hours in advance. Three or more missed appointments within a year per family may also lead to dismissal.

FORM COMPLETION: I understand that there may be a charge for completion of physical, camp, school and FMLA forms.

I have read and understand the Financial Policy of the practice and I agree to be bound by its terms. I understand that I am financially responsible for all charges whether or not they are covered by insurance and agree that such terms may be amended from time-to-time by the practice.
List the name(s) of child(ren) for this account:

Patient Name	Date of Birth	Patient Name	Date of Birth

Parent/Guardian Signature: _____Date: _____
REVISED 08/21/18