



**Shawnee Mission Pediatrics**  
An Affiliate of Children's Mercy

## Financial Policy

Thank you for choosing Children's Mercy-Shawnee Mission Pediatrics as your primary care provider. The following is a statement of our financial policy, which we require you to sign prior to treatment. We are committed to providing excellent medical care. We will make every effort to work with you to file insurance claims and resolve any outstanding balances in a timely manner.

### INSURANCE/DEMOGRAPHIC INFORMATION:

- Insurance coverage is a contract between you and your insurance company. Each insurance policy is individual, and it is the member's responsibility to fully understand their benefits, eligibility dates and what is covered and not covered.
- If the insurance company has not processed and paid the claim within 90 days, the payment of the account will become the responsibility of the parent/legal guardian.
- **Most insurance plans only allow 30 days for a newborn to be added to your policy.**
- It is important we have updated demographic data for both parents so we will be able to contact you in the future.
- **We must always have a current copy of your insurance card on file. If your insurance changes, it is your responsibility to let us know.**
- If prior encounters need to be refiled to a different insurance, you must notify us immediately due to timely filing requirements by your insurance company. If we do not have your updated insurance information, and your claims are denied by your insurance, these charges would become your financial responsibility.
- **NETWORK PROVIDER:** It is your responsibility to know if your physician is considered "in-network" by your insurance. Please call your insurance to verify if there are any question regarding eligibility.

\_\_\_\_\_ **Parent Initials**

### BALANCE/COPAYS

- I understand that any copays are due at the time of service.
- I understand that I am responsible for any balance not covered by insurance.
- **Self-Pay Patients: Full payment for the visit is due at the time of service.**
  - Additional Charges: Please be aware that some services may result in additional charges after your visit. These may include, but are not limited to:
    - Laboratory testing (including tests sent to outside labs)
    - Additional services performed during or after your visit.
    - Higher-level or more complex care visits that require extended evaluation or treatment.
- **In the event of a separation/divorce, the parent bringing the child for the appointment is responsible for payment.**
- Payment plans are available for large balances.
- Failure to pay the balance may result in a restriction of services to all patients associated with the account.

**COLLECTIONS**

- We will send the balance to collections after 180 days of failure to make payments.
- Once an account has been turned over to collections, we will no longer provide medical care to any family members associated with your account.

\_\_\_\_\_ **Parent Initials**

**CREDIT CARD ON FILE**

- Saving a card on file is **required** and will help speed up the check-in process.
- It can be used for copays and balances.
- Any balance under \$200 will be eligible for automatic payment.
- A text will be sent out three days prior to the payment being processed.
- **Contact billing to cancel the payment or to select a different payment method.**
- PAYMENTS: We accept Cash, Check, Mastercard, Discover, Visa, American Express and Debit Cards.

**CANCELLATION OF APPOINTMENTS**

- As a courtesy to other patients and our physicians, we require advance notice prior to canceling appointments.
- There will be a \$25 fee for failure to notify us 24 hours in advance.
- After three no shows, we reserve the right to dismiss you from the practice.

\_\_\_\_\_ **Parent Initials**

**Signature of Parent/Legal Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**HIPAA Acknowledgment**

I acknowledge that I have received or have been given the opportunity to receive a copy of the HIPAA Notice of Privacy Practices for Shawnee Mission Pediatrics.

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**