COVENANT CARE Pediatrics

2019
Patient Payment Option

Patient Name: _____ Date: _____

We offer several options to help you manage your healthcare payments.

In compliance with our contract with your insurance plan, we are required to collect copays at the time of your child's visit. Payment for deductibles, co-insurance, and non-covered services are also due at the time of service unless a credit card or health savings payment card is on file with our office. For patients with a card on file, we only collect a small deposit at the time of service. After the insurance plan process the claim, we will charge the card on file with the patient portions due. We will not charge your card without contacting you first if the claim is denied or appears to be processed incorrectly.

Please choose how you would like to pay for your portion of your child's medical bills. Please initial by your choice.

Option 1: Card on File

___ (initial) I will leave a credit card or health payment card (HAS, HRA, or Flex card) on file.

I authorize Covenant Care Pediatrics to charge my card on file after my insurance carrier processes my claim and indicates the amount due. I understand that leaving my card on file is my consent to these charges and that I will not receive a bill from Covenant Care Pediatrics before my card is charged (your insurance company should send you an Explanation of Benefits beforehand). I understand that leaving my card on file does not mean that I cannot dispute charges with my insurance plan.

I understand that a small deposit towards my deductible may be taken at the time of service.

Option 2: No Card on File

___ (initial) I will pay my estimated patient portion at the time of service with cash, credit card, or health payment card.

I understand that my portion of my child's bill will be due at the time of service. I will be charged the amount my insurance carrier indicates is due. I understand that my insurance plan will still be billed for the services provided and that I may receive an additional bill later if my insurance plan indicates that I owe more than what was collected at the time of the visit. I understand that an additional $15 billing fee may apply.

Parental Consent

I have read, understand, and agree to the option I have chosen above, in accord with the Financial Policies of the Practice.

Parent/Guardian printed name: _____

Parent/Guardian signature: _____