Cascade Pediatrics

FINANCIAL POLICY

Thank you for choosing Cascade Pediatrics as your child's medical home. We are committed to providing high-quality care for your child. Our professional relationship is with you, not your insurance company. Understanding your insurance coverage and benefits is your responsibility. **Patients are responsible for verifying that our providers participate in their insurance plan's network and for understanding their insurance benefits, limitations, and financial obligations**.

INSURANCE

Cascade Pediatrics requires parents to provide accurate and up-to-date guarantor and insurance information. It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company and/or plan, your covered benefits as well as any exclusions within your insurance policy.

Patients are responsible for providing current insurance information at each visit. For insurance plans requiring designation of a Primary Care Physician, one of the Cascade Pediatrics physicians must be listed as the child's Primary Care Physician prior to the appointment.

We will submit a claim to your insurance carrier as a courtesy. However, any charges not covered by your insurance plan are your responsibility. If you have questions regarding specific benefits or non-covered charges, please contact your insurance carrier directly.

PAYMENT OPTIONS

- We accept cash, checks, and major credit cards, including MasterCard, Visa, Discover, and American Express. Patients may choose to securely store their credit card information in our payment processor's secure wallet for online payments.
- Insurance co-payments are due at the time of the visit. Patients are responsible for knowing their required co-payment amount.
- Patients without insurance are required to pay the full cost of services at the time of the visit.
- Patients enrolled in high-deductible insurance plans are required to make payment within 30 days of the visit.
- Saturday appointments are available for **urgent medical needs only**. **All weekend appointments include an additional $25 fee.**

MISSED APPOINTMENTS / LATE CANCELLATIONS

If you are unable to make your appointment, please call us at least 24 hours in advance to cancel or reschedule the appointment. A "No Show" fee of $25.00 will be charged for missed appointments, late cancellations or late reschedules. If any members of a family no show/late cancel/reschedule a total of **four (4)** or more times combined in a 24-month period, the family may be discharged from the practice.

PATIENT STATEMENTS

Outstanding balances are due within **30 days** of billing. Patients who are unable to pay the balance in full are encouraged to contact the billing department to discuss payment arrangements. A final notice of payment, by letter and/or text message, will be issued for balances that are more than **90 days past due.** Balances not paid in full after 90 days may be referred to a collection agency. A **$30.00 fee** will be charged for any returned checks due to insufficient funds, in addition to any bank fees incurred.

PATIENT FINANCIAL RESPONSIBILITY

I authorize payment of medical benefits directly to Cascade Pediatrics LLP for services provided. I also authorize payment of applicable government benefits to the provider who accepts assignment.
I understand that I am financially responsible for payment of all services and materials provided to my family member, including any applicable deductibles, co-payments, or charges not covered by insurance. I understand that it is my responsibility to know and understand my insurance plan benefits.
I agree to make payment for all services within **30 days** of billing unless alternate payment arrangements have been negotiated in advance.
I authorize Cascade Pediatrics LLP to release any medical or billing information required to process insurance claims. This authorization will remain in effect until revoked by me in writing.
I acknowledge that I have read and fully understand this financial policy. I further understand that Cascade Pediatrics LLP reserves the right to amend this policy at any time without prior notice.

Patient Names (list all children): _____ Date: _____

Name of Parent or Guardian: _____ Signature: _____