
**Financial Policy**

Thank you for choosing Upper Valley Pediatrics as your child's health care provider. The following is a copy of our financial policy.

**Payment:** Payment, in full, is due at the time of service. This includes applicable co-pays, co-insurance and payment for services not covered or denied by the insurance company. UVP accepts cash, personal check, debit cards, and all major credit cards. _____(Initials)

**Self-Pay Accounts:** If you do not have insurance, please come prepared to pay for your visit in full upon check out. We offer a 20% discount for all self-pay services paid in full on the day of the visit. If the visit is not paid in full the discount will not be applied. _____(Initials)

**Missed co-pays**: UVP is required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays puts the responsible party and UVP in default of the insurance contract. A $25 service fee will be charged in addition to your co-payment, if the co-payment is not paid by the end of the business day._____(Initials)

**Missed Appointments/Same Day Cancellations:** Missed appointments and same day cancellations represent a cost to us, you, and other patients that could have been seen during the time set aside for your child. Cancellations are required 24hrs prior to any visits via phone call to the practice. A ‘no show’ fee of 60% of that visit charge will be applied if an appointment is missed or cancelled the day of the appointment._____(Initials)

**Outstanding Balances:** If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of statement or within 30 calendar days. UVP does offer a credit card on file option if you are interested please ask the front desk._____(Initials)

**Payment Plans:** UVP understands that full payment may not be possible in certain circumstances. As a courtesy, UVP may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our billing department. Patients with a payment plan must be in full compliance with all conditions of the agreement at the time of the visit. Failure to make scheduled payments on the payment plan, or not paying off a balance in full, may result in your account being turned over to a collection agency and your family not being able to schedule future appointment._____(Initials)

**Collection Accounts:** If your account is submitted to a collection agency, all associated fees are the responsibility of the assigned account holder, including a collection fee equal to 50% of the collection balance. The assigned account holder will receive a written notification by way of a dismissal letter and given 30 calendar days to find a new health care provider. If your account is sent to collections and then paid in full, the assigned account holder may request the practice to reinstate the accounts. If the practice permits reinstatement, there is a $50 reinstatement fee to be charged to the account holder. The fee must be paid prior to scheduling any future appointments._____(Initials)

**Returned Checks:** a $30 fee will be charged for any checks returned for insufficient funds._____(Initials)

**Insurance:** We accept most insurances. Please contact your insurance company to verify we are listed as a contracted provider before scheduling an appointment if you are unsure. Please bring a copy of your insurance card to every visit. Please present newly issued insurance cards upon check-in at the next scheduled visit. If you have a HMO insurance plan, Please assign one of the providers in our practice as your child's primary care provider (PCP) prior to your visit._____(Initials)

**Change of Insurance/Change of Account information:** Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of the changes, the assigned account holder becomes responsible for any and all changes. _____(Initials)

**Billing Inquiries:** Questions about a bill should be directed to our billing department at 802-222-4722. If you have any questions regarding the conditions and terms outlined in this document, please call our office and request to speak to the manager.

*Review and consent of this policy is required prior to services rendered*

Patient's first name:_____ Last name:_____ Date of Birth:_____

My initials above and signature below certifies that I have read and consent to the outlined policies and procedure.

Signature of parent/guardian:_____ Date:_____

Printed name of parent/guardian:_____ Date:_____

**SCAN INTO PATIENT CHART > INSURANCE/BILLING**