Pediatric Partners of Virginia - Financial Policy

At **Pediatric Partners of Virginia**, we are committed to providing excellent care and clear communication regarding financial responsibilities. Please review our financial policy and sign below to acknowledge your agreement.

1. Insurance & Payment Responsibilities

- It is your responsibility to verify that your pediatrician is **in-network** with your insurance plan **before scheduling an appointment**.
- A **valid ID and current insurance card** must be presented at each visit.
- The **insurance policyholder's date of birth and social security number** are required for account verification.
- You are responsible for understanding your insurance coverage, including **deductibles, co-pays, and non-covered services**. Services not covered by insurance must be paid in full at the time of notification of denial.
- **Co-pays are due at the time of service.**
- **Self-pay patients** must pay in full at the time of the visit.

2. Patient Credits & Refunds

- Patient accounts are **reviewed annually** at a minimum.
- If a **credit balance of $10.00 or more** is identified, we will issue a refund using:
  - The **credit/debit card** last used on the account or
  - A **check made payable to the guarantor** on the account.
- If the credit balance remains unclaimed, it may be subject to state regulations regarding **unclaimed property**.

3. Additional Fees

- **Forms Fee** – A **$10 fee** applies for the completion of forms not requested during a preventive checkup.
- **Medical Records Fee** – Charges may apply for medical record requests per state regulations.
- **Missed Appointments & Late Cancellations**: 24-**hour notice** is required for cancellations.
  - **No-show fee:** $50
  - **Rescheduling fee:** $25
- **Returned Checks** – A **$50 fee** will be charged for returned checks.
- **High-Deductible Deposit** – For all non-preventive (non-well) visits, **a $75** deposit is required. This amount will be applied to your patient responsibility after your insurance claim has been processed.

4. Billing & Collections

- **Balances are due within 30 days** of the first statement. If you have concerns regarding billing, please contact our office at **804-323-9100**.
- If no payment is received within **60 days**, a **$10 late fee** will be applied.
- Accounts **90+ days past due** with no payments or broken arrangements and are subject to collections.
- If an account is sent to collections, a **40% fee** will be added to the balance. Any prior discounts will be reversed.
- Unpaid balances, active bankruptcies, or collection activity may not be scheduled until payment is arranged.

5. Financial Assistance & Payment Plans

We understand that unexpected financial difficulties may arise. If you need assistance, please **contact us before your bill becomes overdue** to discuss a **payment plan**. If new charges are added to your balance, updated arrangements must be made.

Acknowledgment & Agreement

By signing below, I acknowledge that I have read, understood, and agreed to the financial policy of **Pediatric Partners of Virginia**.

Patient Names and DOB: _____

_____ _____

Signature of Guarantor | Printed Name | Date

THIS ACKNOWLEDGEMENT WILL BE SCANNED INTO THE PATIENT'S PERMANENT ELECTRONIC MEDICAL RECORD. Revised 03/2026