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Financial Policy

It is important to us that our relationship with patients and families is not clouded by unclear expectations. We would like you to completely understand our financial policy. Please read the following carefully before signing this.

Changes, co-pays and outstanding charges

Please check in at the front desk at every visit with your most recent insurance card. Please inform us of any changes to your insurance policy or demographics. Co-pays are due at the time services are rendered. We will also ask for payment of any outstanding balance. If you are not covered by insurance, you will be self-pay, and payment is due at the time of service.

Deductibles, co-insurance and unpaid claims

Riverside Pediatrics will bill participating insurances on your behalf. If we have not received payment from your insurance company within 45 days of the date of service, you may be expected to pay the balance in full. We are obligated by our insurance contracts to bill you for deductibles, co-insurance and non-covered balance as dictated by your insurance company.

Well visits with extra services

If, during your well visit, you receive treatment for a medical condition outside the scope of routine preventative care, or a pre-existing problem is addressed in the process of performing your regular well visit, your insurance company may advise us that a co-payment is required. If this happens, you will be billed for this co-payment.

Referrals and managed care

If you are enrolled in a managed care plan (HMO) you must receive a referral from our office before you can see a specialist. Referrals should be requested a minimum of 7

business days prior to your visit so that your PCP has time to review and authorize each visit. Backdated referrals are not guaranteed. Failure to follow this process may result in your responsibility for payment of charges incurred at the specialist visit.

Missed appointments

We ask that you, whenever possible, notify our office within 24 hours if you are unable to come to a scheduled appointment. Missed appointments represent a cost to our office and may prevent other patients from being seen at this time. For this reason, we reserve the right to charge a \$25 missed or late-cancelled appointment. Excessive abuse of scheduled appointments may result in discharge from our practice.

Please contact our billing office or the office manager if you have any questions.

Agreement

I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I also understand and agree that I am responsible for full payment of non-covered services, medical record fees, returned checks, and missed appointments. I will notify Riverside Pediatrics of any changes to my insurance coverage and contact information.

Responsible party: _____

Relationship of parent: _____

Signature: _____

Date: _____