C·I·C·S
Children's Integrated Center for Success

Financial Policy

1247 S. Cedar Crest Blvd, Suite 100 • Allentown, PA 18103
610-770-1800 • www.everychildeverytime.com

CHILDREN'S INTEGRATED CENTER FOR SUCCESS FINANCIAL POLICY

INSURANCE: It is **YOUR RESPONSIBILITY** to verify that your policy is in force on your date of service and to understand the insurance carrier's coverages, rules, and regulations.

All co-pays, co-insurances, deductibles and charges not covered by your insurance are your responsibility and WILL BE BILLED TO YOU BY OUR OFFICE.

CO-PAYS ARE DUE AND MUST BE PAID IN FULL AT THE TIME OF YOUR VISIT

If you DO NOT have insurance or you have an insurance we do not participate with, we expect payment IN FULL for all treatment at the time of service unless other arrangements have been made.

If your insurance requires a **PRE-AUTHORIZATION** prior to your visit, **IT IS YOUR RESPONSIBILITY TO ALERT THE OFFICE 5 DAYS PRIOR TO YOUR VISIT** so that we can obtain the pre-authorization.

Our office accepts Visa, MasterCard, Discover, American Express, checks, and cash. All payments are expected at the time of service. A $25.00 charge will be assessed to all accounts whose check does not clear the bank.

COLLECTIONS: Patient accounts will be **turned over to a collection agency after 90 days** if the balance is not paid in full or payment arrangement have not been made with the billing department. You will be responsible for any fees charged by the Collection Agency. Accounts turned over to collections may result in dismissal from the practice.

MISSED APPOINTMENTS: Cancellations are requested **24 hours** prior to the appointment. We do understand that emergencies do occur, so please call as soon as you know you are going to miss your appointment. **NO SHOWS** (no call) will be billed a $25.00 missed appointment fee. Excessive abuse of scheduled appointments may result in discharge from the practice. We reserve the right to charge for missed appointments.

RELEASE OF INFORMATION: I authorize Children's Integrated Center for Success to release any of my/my child's information and/or records to all my insurance companies to substantiate claims and payments.

PLEASE READ, SIGN, AND RETURN TO FRONT DESK. IF YOU WOULD LIKE TO KEEP A COPY FOR YOUR RECORDS PLEASE REQUEST A COPY AT THE DESK.

I HAVE READ AND FULLY UNDERSTAND THE FINANICAL POLICY SET FOR BY CHILDREN'S INTEGRATED CENTER FOR SUCCESS AND AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

Signature of Patient/Guardian: Date:

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