



Financial Policy

Patient last name: _____

First name: _____ MI: _____

Date of birth: _____

Responsibility for payment

It is expected that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred.

Acceptance of your health insurance

We accept most insurance plans and are participating providers in most local HMO's. Please check with the office to confirm that we accept your insurance.

We will file insurance claims; however, you are ultimately responsible for payment of your child's bill. In order to file your claim, we will need your insurance company information. Please present your current insurance card at each visit. Unfortunately, we are unable to file insurance claims internationally; payment in full is expected at the time of the visit for international patients.

It is the responsibility of the parent/guardian to know and understand the details of their child's health insurance coverage. There are numerous health insurance coverage plans and it is impossible for our staff to predict which services will be covered by your plan. If your insurance company does not cover 100% of the services rendered, you are responsible for the bill.

Co-payments and any prior patient balance are due when your child checks in to be seen in the office. For your convenience we accept cash, check, MasterCard, Discover and Visa for payments.

Self pay patients

If you do not have health insurance or we do not accept your health insurance, payment in full is due at the time of your visit. If you are leaving the country, it is expected you will provide us with contact information for any outstanding balances.

Patient responsibility

HMO insurance plan

Your insurance plan may require that you identify a Primary Care Physician (PCP) for your child. If this notification is not on file with your insurance plan, payment for services may be denied. Please notify your insurance company if you change PCPs or insurance.

Services requiring a referral, pre-certification or authorization

Your insurance may not pay for certain visits or services unless you have a referral from your Primary Care Physician (PCP). After you have made the specialist appointment, it is your responsibility to notify Belmont Cambridge Health Care and provide the appointment date and specialist's name in order to request a referral. Please allow our staff as much notice as possible. If you do not obtain a referral, you may be responsible for the cost of these services.

Patient balances

All patient balances must be paid within 30 days of receiving a bill from Belmont Cambridge Health Care. If you have not paid your balance in a timely manner, your account will be reviewed for collection agency placement.

Belmont Cambridge Health Care is not party to any legal agreements between divorced or separated parents. The parent (guardian) accompanying a minor to an appointment is responsible for payment.

Records, correspondence and forms

Copies of pertinent medical records are available to the patient and/or the parent/guardian for a fee after we have received a signed release. If you transfer out of the practice, you may request copies of your child's medical record. There will be a fee for additional copies.

A Health Form is provided each year at your child's well visit with updated immunization records. These are often required for camp or school so please ask the front desk to print yours before you leave.

All other documentation requests, other than the insurance company requirements, will incur a fee.

Financial policy agreement

- I certify that I have read the Belmont Cambridge Health Care Financial Policy and acknowledge full financial responsibility for the services provided to me or my children by Belmont Cambridge Health Care.
- I understand that I am responsible for payments of any portion of the charges not covered by insurance; including co-payments, deductibles, co-insurance, and non-covered services.
- I understand that I am responsible for prompt payment of charges if I do not have medical insurance or if Belmont Cambridge Health Care is a non-participating provider with my health insurance.
- I consent to the assignment of my insurance benefits to Belmont Cambridge Health Care for services provided to me or my children.

Name: _____

Signature: _____

Relationship to patient: _____ Date: _____