Financial Policy

Insurance Plans and Policies

Kids and Tummies, LLC participates in most insurance plans.

It is your responsibility to check with your insurance plan prior to your visit to make sure we are in network.

If you have an insurance that requires a referral, it is your responsibility to contact your PCP (Primary Care Physician) prior to being seen. If we do not have a referral on file, the bill is your responsibility.

Knowing your insurance benefits is your responsibility.

As a courtesy, Kids and Tummies, LLC will verify your insurance and take care of any precertification that may be needed prior to any endoscopy procedures.

Proof of Insurance

A copy of a valid insurance card will be needed on the day of your appointment.

It is your responsibility to provide our office with this information. If you do not have a copy of your card, you will be considered a self-pay patient.

Copayments and Billing Statements

Copayments are due at the time of your visit.

All copayments and deductibles are based upon Primary Insurance coverage.

Please remember that we are contractually obligated by your insurance company to collect copayments and deductibles.

We will file your charges with your insurance company. You will be responsible for payment of any remaining balance.

If any deposit or copays are due at the time of your endoscopy procedure, our office will let you know ahead of time so you can make appropriate arrangements.

If you cannot pay your balance in full, our office will be happy to set up payment arrangements. It will be your responsibility to contact our billing department and arrange a payment plan.

We accept Cash, Check, or Credit Cards

Returned checks are subject to a $30.00 NSF charge.

If you do not cancel any endoscopy procedure appointments <u>within 24 business hours</u> of the procedure date, you will be charged a $100.00 cancellation fee.

Failure to receive your statement does NOT relieve you from your financial obligation. It is the patient's responsibility to notify our office with any address or contact information changes.

Patient Name _____

Date of Birth _____

Signature (Patient or Legal Representative for Patient) _____

Today's Date _____