



www.PerformancePediatrics.com

Partnering with Families through Childhood Milestones

23 Aldrin Rd
Plymouth, MA 02360
508-747-8277

Financial Policy

Performance Pediatrics physicians and staff are committed to providing you with the best possible care. Your clear understanding of our Financial Policy is important to our professional relationship. Please read this document to become familiar with our current Financial Policy. Once all of your questions have been answered, please sign this document. We will provide a copy to you for future reference.

Patients with Insurance: We are a participating provider with a number of insurance plans. Please bring your insurance card with you at the time of your appointment. You will be asked to pay all co-payments at the time of service. If your health insurance company does not cover 100% of the services rendered, you are responsible for any co-insurance, deductibles or non-covered services that are not paid by your insurance. You will receive a statement from our office indicating the amount your insurance has paid and the amount you owe. Any balance remaining is due from you within thirty (30) days of your receipt of the statement.

Patients without Insurance: If you are uninsured and self-pay at the time of your appointment, you will receive a 20% discount if you do not have an outstanding account balance with us. If you have an outstanding account balance with us, or you are not able to pay at the time of your appointment, you will receive a bill for the full cost of the services provided to you.

Payment Following an Appointment: Regardless of your insurance status, if you are not able to pay any amount owed at the time of your appointment (i.e., the amount of your co-pay, co-insurance, deductible, non-covered services, uninsured services), and you must be billed by us, we will mail a statement to you within two days of service or when we are alerted by your insurer that you must make a payment to us, as applicable. Payment is due from you to us within thirty (30) days of your receipt of the statement. In the event you fail to make the payment within this timeframe, we will provide your name, contact information, and payment information to American Profit Recovery (APR), a national debt collection agency. APR will then seek payment from you. In the event you continue to fail to pay the amount owed, we will notify you, by certified mail, that you have been dismissed from the Performance Pediatrics practice, and that you must find a new provider. For a period of thirty (30) days from the date you receive the notification from us, Performance Pediatrics will treat you for urgent matters only.

Financial Assistance: In the event that you alert us that you need assistance with paying for medical services, we will refer you to the Commonwealth Connector, an independent Massachusetts agency that can help you find a health insurance plan that meets your needs.

If you have any questions or concerns, please contact the Administrative Director at:
508-747-8277.



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Signature Page

Patient's name: _____

D/O/B: _____

Address: _____

I certify that I have read this Financial Policy, I understand this Financial Policy, and I will comply with this Financial Policy. I acknowledge full financial responsibility for the services provided to me or my minor children by Performance Pediatrics. I understand that I am responsible for prompt payment of any portion of the charges not covered by my insurance, including co-pays, co-insurance, deductibles and non-covered services. I understand that I am responsible for prompt payment of all charges in the event that I do not have health insurance, or that Performance Pediatrics is not a participating provider with my health insurer. I consent to the assignment of authorized insurance benefits by my health insurer to Performance Pediatrics for any services furnished to me or my minor children.

Signature _____

Date _____

If the patient is under 18 years old or is otherwise incompetent to consent, this document must be signed by the patient's parent, legal guardian, or other duly authorized representative.

Relationship to Patient _____