Rocky Hill Pediatrics

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FINANCIAL POLICIES

Thank you for choosing Rocky Hill Pediatrics for your child's pediatric care. We are committed to providing quality and affordable health care. Part of our responsibility to our patients is to keep you informed of our financial policies. Please feel free to speak with our billing department if you have any specific questions or concerns.

Insurance

We participate with most insurance plans. If you are insured with a participating plan you must bring a valid insurance card to every visit. If you have more than one insurance, you must bring a copy of all valid insurances. Failure to provide up to date insurance information at the time of service may result in patient responsibility for the entire bill. You are responsible for all co-insurances, deductibles, and non-covered services. Our billing department will send a bill for any balance owed after submitting the claim to your insurance.

Copayments

All copays are due at the time of the visit and it is your responsibility to know of any copays that are due.

Self-Pay

If you do not have coverage with a participating insurance plan, payment is required in full at the time of visit unless prior arrangements have been made with our billing department.

Additional Fees

Visits outside of normal business hours, on weekends, or on holidays may incur an after-hours fee. Additionally, if your child needs to be seen without an appointment you may be charged a fee for an emergency walk-in. These fees are covered by most insurance plans, but may be put to patient balance. All returned checks will incur an additional fee of $25.

Missed Appointments

If you are unable to keep your appointment we ask that you notify the office 24 hours in advance. We reserve the right to charge a fee of $50.00 for no-show appointments.

Payment

Unless other arrangements have been made with our billing department all bills are due within 30 days of receipt. If you are having financial difficulty, please contact our billing department at (860) 721-7561.

I have read and understand the above financial policies of Rocky Hill Pediatrics (RHP) and agree to abide by its guidelines. I request that payment of authorized insurance be made on my behalf to RHP for any services rendered. I authorize RHP to release medical information necessary to receive payment from my insurance company.

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Signature of Parent/Guarantor Date

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Relationship to Patient