

Financial Policy
(Effective April 1, 2021)

Thank you for choosing Bloom Pediatrics as your child's health care provider. The following is a copy of our financial policy. Patient care is not permitted without the written consent of receipt and acknowledgement of the understanding of this policy.

Payments:

Payment, in full is due at time of service. This includes applicable co-insurance, co-payments, and payments for services not covered or denied by the insurance company. Bloom Pediatrics accepts cash, personal check, debit cards, Visa, Mastercard, Discover, and American Express. We also accept Apple Pay. _____
Initials

Self-Pay Accounts:

If you do not have insurance, please come prepared to pay for your visit in full upon check-out. A price list of services is available upon request. We offer a 20% discount for all self-pay services paid in full on the day of the visit. _____
Initials

Missed Co-Pays:

Bloom Pediatrics is required by our insurance contracts to collect all co-pays at the time of service. Failure to collect co-pays puts the responsible party and Bloom Pediatrics in default of the insurance contract. A \$25 service fee will be charged in addition to your co-payment, if the co-payment is not paid by the end of that business day. _____
Initials

Missed Appointments:

Missed appointments represent a cost to us, you, and to other patients that could have been seen during the time set aside for your child. Cancellations are required 24 hours prior to any well visit appointment and two hours prior to any sick visit appointment via phone call to the practice. A "No Show" fee of \$50 will be applied if an appointment is missed and not cancelled within the stated timeframe. _____
Initials

Outstanding Balances:

If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of statement or within 30 calendar days. _____
Initials

Payment Plans:

Bloom Pediatrics understands that full payment may not be possible in certain circumstances. As a courtesy, Bloom Pediatrics may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our management team. Patients with a payment plan must be in full compliance with all conditions of the agreement at time of visit. Failure to make scheduled payments on the payment plan, or not paying off a balance in full, may result in your account being turned over to a collection agency and your family being dismissed from the practice. _____
Initials

Collection Accounts:

If your account is submitted to a collection agency, all associated fees are the responsibility of the assigned account holder, including a collection fee equal to 50% of the collection balance. The assigned account holder will receive written notification by way of a dismissal letter and given 30 calendar days to find a new health care provider. If your account is sent to collection and then paid in full, the assigned account holder may request the practice reinstate the account. If the practice permits reinstatement, there is a \$25 reinstatement fee to be charged to the account holder. The fee must be paid prior to scheduling any future appointments. _____
Initials

Returned Checks:

A \$30 fee will be charged for any checks returned for insufficient funds. _____
Initials

After Hours/Holiday Care:

There is a \$40 fee for non-preventative care visits that occur after 5:00pm (EST) daily, on weekend days and federal holidays. If that fee is not covered by your insurance carrier, the assigned account holder is financially responsible for the charges. _____

Initials

Insurance:

We accept most insurances including most Medicaid plans. Please call the office to confirm acceptance of your coverage.

Please bring a copy of your insurance card to every visit. A scanned copy of the assigned account holder's current insurance card and driver's license is required to be kept on file. Please present newly issued insurance cards upon check-in at the next scheduled visit.

If you have an HMO insurance plan, please assign one of the physicians in our practice as your child's primary care physician (PCP) prior to your visit. If we cannot confirm that one of our providers is listed as your child's PCP, we will ask that the appointment be rescheduled. _____

Initials

Change of Insurance/Change of Account Information:

Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges. _____

Initials

Billing Inquiries:

Questions about a bill should be directed to our billing department at 1-866-371-6118.

If you have any questions regarding the conditions and terms outlined in this document, please call our office at 248-645-1740 and request to speak with a manager.

Review and consent of this policy is required prior to services rendered after April 1, 2021

Patient's First Name: _____ Last Name: _____ Birth Date: ___/___/___

My initials above and signature below certifies that have read and consent to the outlined policies and procedures.

Signature of parent/guardian

Printed name of parent/guardian

___/___/___
Date