Financial Policy

We are committed to providing you with the best care possible. This goal is best achieved if everyone is aware of the financial policy, which is an agreement between the doctors of the practice and the child's parent or guardian. Your clear understanding of the financial policy agreement is important to our professional relationship.

Appointment Scheduling Policy

1. In compliance with Telehealth laws our providers will only be able to provide services if the patient is located at the time of service in the state the pediatrician is licensed in. If the patient is not located in the specified state at the time of the appointment, the appointment will be rescheduled to the first available date with a pediatrician licensed in that state
2. We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 48-hour notice. There may be a charge of $30 for missed or canceled appointments without 24-hour notice.
3. For more than three missed appointments per family, we may refuse to schedule any subsequent visits.
4. If you are more than 5 minutes late for your appointment, we will do our best to accommodate you. However, it may be necessary to reschedule your appointment. Please notify our team if you are running late by calling (866) 219-8595.
5. Our team will make multiple attempts to connect with you and remind you to complete the required paperwork for confirming your child's evaluation appointment.

Insurance

1. It is the responsibility of the parent/guardian to provide accurate and timely insurance information. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the parent/guardian being responsible for payment.
2. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. An estimate of the patient responsibility portion will be provided prior to services rendered although true balance due may differ after the insurance processes the bill.
3. You are responsible for any and all co-payments, deductibles, coinsurance, and non-covered items up to the full billed amount. All insurance carriers have a fee schedule from which they will reimburse. However, the provider's fee may be higher than what the insurance company reimburses, or it may not be a covered service. Therefore, any balances not covered by insurance becomes the responsibility of the parent/guardian.
4. All services performed will be submitted to the insurance carrier that you provide to us.

Financial Responsibility

1. Insured Patients: Balances due will be sent via paper and/or electronically every 30 days and will reflect balances due according to your insurance company's explanation of benefits.
2. Self-Pay Patient: Patient balance statements will be sent via paper and/or electronically within 1 day of the completed appointment.
3. A $30 fee may be charged for all credit card transactions that are declined. Same fee applies for returned or insufficient funded checks.
4. If previous arrangements have not been made with our billing office, any account balance outstanding longer than 180 days may be forwarded to a collection agency.
5. The parent or adult signing this consent is financially responsible for any balances due. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.

6. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Phone: (866) 219-8595
Email: support@asyouare.com

We're here if you have any questions. Email us at support@asyouare.com or call (866) 219-8595.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY AS YOU ARE. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY AS YOU ARE AT ANY TIME WITHOUT PRIOR NOTIFICATION.

Signature: ____ Date: _________________________________