150 LOWER WESTFIELD ROAD ● HOLYOKE, MASSACHUSETTS 01040 ● TELEPHONE (413) 536-2393
84 WILLIMANSETT STREET ● SOUTH HADLEY, MASSACHUSETTS 01075 ● TELEPHONE (413) 532-0300

Thank you for choosing Holyoke Pediatric Associates, LLP as your health care provider. We are committed to providing you with quality health care. Because some of our patients have had questions regarding patient and insurance responsibility for services, we have developed this payment policy to assist you. **Please read this policy carefully, ask us any questions you may have, and sign below in the space provided**.

1. **Insurance.** Your insurance policy is an agreement between you and your insurance company. We are not a party to your insurance contract. You are responsible for knowing your insurance benefits. Please contact your insurance company with any questions you have regarding your coverage. As long as you provide us with accurate insurance information, we will bill your insurance company. By signing this form you are giving Holyoke Pediatric Associates, LLP permission to bill your insurance company on your behalf.

2. **Co- Payments, Coinsurance, and Deductibles.** All co-payments are due at time of service, if co-payment is not paid at time of service a $15 late fee will be incurred. All coinsurances, and deductible payments are due upon receipt of the first billing statement, and must be paid directly to Holyoke Pediatrics. You understand that you are responsible for these fees, and if you do not pay these fees, Holyoke Pediatric may seek alternative methods to collect these monies. You understand that if Holyoke Pediatric collects any applicable co-payment, coinsurance, or deductible from you and is also reimbursed directly from your insurance company, that you will be reimbursed by Holyoke Pediatric for any overpayment owed to you no later than forty-five (45) days after Holyoke Pediatric' s receipt of insurance company notification.

3. **Non-covered Services.** Please be aware that some, and potentially all, of the services you receive may not be covered or may not be considered reasonable or necessary by Medicaid or other insurers. You understand and agree that you will be responsible to pay for these services in full, and are due upon receipt of the first billing statement.

4. **Proof of Insurance.** All patients must complete our patient information forms before seeing a physician. We must obtain a copy of your insurance card, and we must be able to verify the insurance as proof of current and valid insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the charges for services you receive.

5. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help you get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that **charges for services received are your responsibility**, whether or not your insurance company pays your claim.

HOLYOKE PEDIATRIC ASSOCIATES, LLP

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6. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can update your information accordingly. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all charges for services you received.

7. **Nonpayment.** You understand and agree that you are responsible for all fees associated with services received by you, including but not limited to non-covered services, co-payments, coinsurance, and deductibles. Please be aware that if you fail to pay these fees, Holyoke Pediatric may seek alternative methods to collect these unpaid monies. You understand that if a balance remains unpaid for a more than 120 days past due that Holyoke Pediatric may discharge you and your family members from this practice and terminate the doctor healthcare practitioner-patient relationship.

Holyoke Pediatrics is committed to providing the best treatment to our patients. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have fully read and understand that I am responsible for any portion of my bill that is not covered by my insurance company.

_____ _____
Patient Name Date of Birth

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Print Name Relationship to Patient