PEEK A BOO
Pediatrics

821 N. 2nd St.
Philadelphia,PA 19123
Phone: (267) 7023850
Fax: (267) 8584617

Financial Policy

Thank you for choosing Peekaboo Pediatrics as your healthcare provider. If you have any questions we will be happy to discuss our fees and policy with you anytime.

Payment for services is due at the time services are rendered. For any portion of your balance that is not covered by insurance, or for our private pay patients, we accept cash, check or credit card.

Insurance Policy

We participate with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know know what are your particular benefits may be.

1. Your insurance policy is a contract between you (your employer) and the insurance carrier. We are NOT a party to that contract. Our relationship is with you. We cannot become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurances, and "usual and customary charges". Therefore it is important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

2. If your insurance company does not pay your claim within 30 days, it is your responsibility to contact your insurance to expedite payment. If your insurance company does not pay within 60 days you will be responsible for payment.

Copayments and Deductibles

1. Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected at the time of service. Payment may be made in cash, by check or by card. We also accept Health Savings Account (HSA) cards for payment.

2. Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the office. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full , it is likely than any non-preventive servise will require payment at the time of those services are rendered.

3. All charges are your responsibility whether your insurance company pays or does not pay. Not all services are a covered benefit in all contracts. Please check your insurance plan or document for any questions.

4. Copayments NOT PAID at the time of service are subject to a $10 processing fee. All balances more than 60 days past due are subject to a penalty of $10 per month to cover the cost of sending additional statements.

Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

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Checks

1. Returned checks and balances older than 90 days may be subject to collection placement and collection fees which will be charged to the responsible party.

2. There will be a $25 NSF charge on all returned checks

Overpayment

Occasionally payment results in overpayment on your account and generally this balance remains on your account as a credit for use at a future visit. You may request a refund of overpayment by notifying the Office.

Credit Card On File

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, we require that a valid credit card be kept on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email.

Appointments

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of at least 1 business day for all cancellations. Failure to notify the office in a timely manner more than once may result in a no show fee of $25 which will not be covered by your insurance plan.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate with our office any such problems so that we can assist you in management of your account with a payment plan.

Again, Thank You for choosing Peekaboo Pediatrics. We appreciate the opportunity to serve you.

I have read and understood the above policy and agree to it.

Parent/Guardian Name _____ Relationship to patient _____

Signature _____ Date ____/____/____

Patient/Child's Name _____