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FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal of providing the best pediatric care by highly qualified professionals specialized in pediatric and adolescent medicine. The following policies reflect our aim to keep up to date information on file, collect co-pays upfront, minimize involvement of a collection agency by promptly collecting patient balances, deter patients who do not show for appointments and let parents be responsible for knowing what kind of coverage their child's insurance company provides. Please read this carefully and if you have any questions, please do not hesitate to ask our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND FILING YOUR OWN INSURANCE.
2. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
3. It is your responsibility to understand your benefit plan, to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
4. If you have no insurance, payment for an office visit is due at the time of the visit.
5. Co-payments are due at time of service.
6. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 business days of receipt of your bill.
7. Any balance over 60 days will be forwarded to a collection agency.
8. We request 24-hour notice for canceling any appointments.
9. A \$30 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
10. We charge a \$20 flat fee plus .50 cents per page for copying the medical record of your child.
11. Before making an annual physical exam appointment or getting immunizations, check with your insurance company if the visit will be covered. Not all plans cover annual physicals exams or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
12. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Personal Health Information (PHI).

Patient Name(s) _____

Print Name of Responsible Party

Relationship

Responsible Party's Signature

Date