Financial Policy

Our goal at Garden Pediatrics is to provide and maintain great physician-patient relationships. Letting you know in advance of our financial policies allows for a good flow of communication and ensures that we achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to contact a member of the front office team.

Fees for Service

We encourage all patients who have questions or concerns about the cost of care to inquire about those costs in advance of service. Garden Pediatrics follows the American Academy of Pediatrics (AAP) guidelines for care provided to our patients. If deemed medically necessary, we will administer care according to those guidelines and patients will incur associated fees. In some cases, we can identify alternative, less expensive paths of treatment for certain cases. In most cases, Garden Pediatrics providers are proactively weighing the benefits of care provided vs. cost to patient family and no lower-cost alternative exists. Please note that we will not compromise quality patient care in attempting lower-cost treatment plans.

Time-of-Service Payment Discount

We offer a courtesy Time-of-Service Payment Discount to those of our patients that do not have insurance coverage. We offer a 30% discount off of our regular visit fees when you make payment at the time services are received.

Please note: *discounts apply to services only. Discounts are not applied to products such as vaccines, labs or radiology tests and other like products.*

No Show, Cancelation, and Late Policies

Please arrive 15 minutes prior to your first visit to allow time for paperwork and registration. On returning visits, we ask you to arrive *10 minutes prior to your appointment time*. No-show fees and cancellation fees will apply to all visits, as applicable. A no-show fee is incurred where no notice is provided for not being able to arrive at an appointment and/or patient families arrive without correct insurance information. Cancellations occurring within 24 hours of appointment time will incur a cancellation fee. The current no-show fee is $100 and the current cancellation fee is $75. All fees are subject to change without notice.

No show policy for IEHP and Medi-Cal families: Three (3) no shows will enact patient reassignment, per IEHP and Medi-Cal policies. Please review your member rights and responsibilities under section 22, as it states that if you make an appointment for routine and sick care and cannot attend, you must inform the doctor's office prior to visit.

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Guardian Initials

For patients with an insurance plan we do not accept:
Please refer to the Fees for Service and Time-of-Service Payment discount sections for assistance. In many cases, Garden Pediatrics will be considered an 'Out-of-Network Provider' for these insurance plans. You may have an opportunity to complete paperwork required by your insurance carrier to receive a partial reimbursement for your visit fees. Please contact your insurance carrier for more details and for copies of the required paperwork. Insurance carriers change their requirements and their participation regularly, so contact your carrier for the latest information.

For patients with insurance plans we accept:
At the time of this printing, Garden Pediatrics accepts many of the following insurance carriers PPO programs: Aetna, Anthem Blue Cross, Blue Shield, Blue Cross/Blue Shield, Cigna, HealthNet, Pacificare, Tricare and United. We also accept a limited number of IEHP and Medi-Cal patients.
Your contractual payment (co-pay etc) is due at the time of service according to the insurance program you established with your carrier. It is our policy and our contractual obligation with your insurer to collect co-payments, co-insurance and deductibles at the time of service. Insurance carriers change their requirements and their participation regularly, so contact your carrier for the latest information about your program.

Please follow these steps to ensure proper processing of your insurance plan coverage.

1. On arrival, please check in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card any time there is an insurance change. This is your verification of the correct insurance and consent to bill the insurer on your child's behalf. If the insurance company that you designate is incorrect, the insurance carrier will deny the claim and you will be financially responsible for those services. Most insurance companies have filing timeline limits, and by the time a claim is denied, it is often too late to collect from another insurance company. You will be responsible for payment in the event any insurance company denies the claim.
2. If Garden Pediatrics is your primary care physician, please make sure that our name or phone number appears on your card (where applicable). If your insurance company has not been informed that we are your primary care physician prior to the date of service, the insurance carrier may deny the claim and you will be financially responsible for the visit.
3. According to your insurance plan, you are responsible for paying any and all co-payments, deductibles, and coinsurances, and we have a contractual obligation with your insurer to collect those payments. We will collect those fees, per contract.
4. We will submit to secondary insurance plans but please clearly inform us if more than one insurance and which one is primary.
5. Please make it a priority to understand your insurance benefit plan prior to your visit. Some plans are extremely complex and you may need several discussions with insurance agents before your plan is fully understood. Patient families are responsible for understanding your insurance plan. Further, it is your responsibility to know (1) if a written referral or authorization is required to see specialists, (2) if preauthorization is required prior to a procedure, and (3) what services are covered. If you are not sure what is required, please contact your insurance carrier for assistance prior to your visit.
6. If you owe Garden Pediatrics a balance, we require all prior balances to be paid prior to the next visit. If you do not coordinate payment before the next appointment, you may be denied service and/or you may be charged an additional no-show, cancellation, or other fee.

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Guardian Initials

7. Co-payments and co-insurance is always due at the time of service. A **$10 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
8. Once we receive your insurance plan's explanation of benefits (EOB), any balances due from you according to your insurance plan will be billed upon receipt of that explanation. Your payment terms will be listed on the bill and are not negotiable.
9. Account balances outstanding greater than 30 days will incur interest at 20% per annum, billed monthly, until the balance reaches $0. Garden Pediatrics uses external agencies who report to credit agencies, where required.
10. Returned checks will incur a **$25** fee plus bank fees.
11. Advance notice is needed for all non-emergency referrals, so please allow 5 business days to create a referral. While we will make every effort to refer you to a physician participating in your plan, if you are requesting a referral to a specific provider it is your responsibility to know if that selected specialist participates in your plan. Please note that your plan may not cover referrals to out-of-network providers and therefore those charges may be billed directly to you.
12. Before making appointments for well visits, please check with your insurance company to ensure the visit will be covered. Many plans cover well visits only at specified intervals. For any services not covered by your insurance carrier and/or your insurance plan, you will be responsible for payment at the time of visit.
13. Not all services provided by our office are covered by every plan. Any service determined as not covered by your plan will be billed directly to you, so please consult with your insurer about any services that may be excluded in your policy.

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 herein.

Patient Name(s)

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Financially Responsible Party Name (please print) Relationship

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Signature Date