



Financial Policy

GHT currently only accepts PPO insurance, discounted cash pay (self-pay), and concierge patients.

Insurance Coverage

Your insurance plan is a contract between you and your insurance company. It is your responsibility to understand the benefits and coverages your medical plan provides. **Growing Healthy Together and our providers are registered as in- and out-of-network providers. Your insurance plan typically covers both; however, check your specific policy for coverage amounts and details.** Bring your insurance card with you for each visit. Providing your insurance card and information does not guarantee payment from your insurance company. If we do not have your current, active insurance policy on file, you may be asked to pay at the time of service.

Cash Patients

Payment in full is required at the time of service. Exam fees do not cover add-on services like additional tests, screenings, vaccines, or procedures. Refer to our Services & Costs sheet for more information. Exceptions to this policy must be arranged with management before your visit.

New Patient Appointment Deposit

A \$50 non-refundable deposit per patient is **required** for new patients to confirm and hold their appointment at the time of scheduling. If you keep your appointment, the deposit is applied to the cost of the visit or applied to a future visit. If you cancel your appointment at least 24 hours before, the deposit will be used for a future appointment. If you miss the appointment, you will lose your deposit.

Newborn Registration

You have 30 days to add your newborn to your insurance. If you do not add them within 30 days, you will be retroactively charged the total insurance cost per visit. For all future visits, you will be charged the discounted cash pay (self-pay) rate.

Consults, Preventative Care, & Sick Visits

Claims are billed based on your provider's clinical evaluation and diagnosis during exams. A preventative care appointment can become an office consultation or sick visit, resulting in copays, co-insurance, or deductibles that are the patient's responsibility to pay. For example, it will become a consult or sick visit if you require assessment, evaluation, or provider intervention during a vaccine-only appointment.

Telemedicine, Spruce Messages, and Virtual Appointments

Telemedicine, Spruce messages, and phone calls **are subject to insurance or self-pay billing**, determined by your provider's medical evaluation and clinical judgment at the time of the exam. Co-pays, co-insurance, and deductibles may apply.

Coordination of Benefit Holds (COB)

A claim may be placed on a COB hold if the insurance company needs to verify whether the patient had dual coverage at the time of service or if the insurance company requires additional information before processing the claim. If a claim is unpaid due to a COB hold, the member must clear the hold within 30 days of notification. Uncleared claim amounts due to COB holds are the patient's responsibility to pay without a guarantee of reimbursement or reprocessing by the insurance company.

Co-Pays, Deductibles, and Co-Insurance

Co-payments are due at check-in before being seen by your provider. Co-insurance and deductible amounts are determined by your contract with your insurance company. After your insurance company has processed a claim, any balances they determine are the patient's responsibility will be billed to you to be **paid within 30 days of receipt**.

Late and Missed Appointments

All appointments must be confirmed before the date of service. If you cannot make your appointment, we require a 24-hour cancellation notice. If you are running late, please notify the office. We may need to reschedule your appointment so our providers can spend adequate time with your child and other patients. **A \$50 late/no-show fee per patient is charged for those who do not notify us of late arrival and appointment cancellations within 24 hours of the visit.**

Non-Covered Services

"Services" describe any interaction or service provided by an employee of GHT, including but not limited to wellness, office, sick, vaccine-only, nurse-only, and consultation visits.

Returned Check Fee

If your payment is made by e-check or paper check and the check is returned from the bank as dishonored, a **\$25.00** return check fee will apply.

Transaction Fee

If a credit card payment is returned, declined, or incorrectly disputed, a **\$25.00** processing fee will apply.

Form Fee

Patients often request various forms (school, disability, etc.) to be completed by GHT. Forms require review and completion of a medical history by our providers. Our documentation fee is **\$25.00** and must be paid in full at the time forms are submitted. As a courtesy, we waive this fee if the patient provides forms during their scheduled visit.

Unpaid and Outstanding Balances

Full payment of all outstanding balances must be made before your next appointment unless prior arrangements have been made through our billing department. You may also set up payment arrangements through our billing department if necessary. **Overdue balances will be sent to collections.**

We offer convenient ways to pay your bill.

You can submit payments through online bill payment after creating your patient portal account. You can also mail us your payments or call our office at (562) 473- 4441 for assistance.

I understand if I have an unpaid balance to Growing Healthy Together and do not make satisfactory payment arrangements, my account will be placed with an **external collection agency**. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.

For Growing Healthy Together or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Growing Healthy Together and the designated external collection agency are authorized to:

- (i) *Contact me by telephone at the telephone number (s) I am providing, including wireless telephone numbers, which could result in charges to me,*
- (ii) *Contact me by sending text messages (message and data rates may apply) or emails using any email address I provide and*
- (iii) *Contact methods may include pre-recorded/artificial voice messages and/or automatic dialing devices, as applicable.*

Furthermore, I consent to the designated external collection agency to share personal contact and account-related information with third-party vendors to communicate account-related information via telephone, text, e-mail, and mail notification.

By signing, I acknowledge that I have read and understood the policies of Growing Healthy Together described above. I agree to be personally responsible for all applicable fees.

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name (if applicable): _____

Primary Phone: _____ Primary Email: _____

Signature: _____ Date: _____