Dr. Carey Molin Gully, MD, FAAP
(864) 888-4464
(864) 888-4462 fax
www.blueridgekids.com

Blue Ridge Pediatrics

Professional, Personalized Care for Newborns, Children & Adolescents

North Park Office Park
457-B Hwy 123 Bypass
Seneca, SC 29678

FINANCIAL POLICY

The following financial policy has been developed to allow the office of **Blue Ridge Pediatrics, LLC,** to provide the highest quality of care at the lowest cost to you, our patient.

Patient Name: ______________________________ Date of Birth: ______________________________

Co-Pays & Deductibles	All insurance plan co-pays are payable upon Check In. Deductibles are payable upon Check Out. It is the patient's responsibility to be aware of their co-pays and/or deductibles at the time of service.
Self-Pay	Payment is expected at the time of service. We except cash, check, Visa or MasterCard for your convenience. If the patient has an outstanding balance with our office it must be paid in full before being seen again. If the balance cannot be paid in full, payment arrangements will need to be made. You may do this by contacting the Billing Department at (864)888-4464.
Medicaid	You will need to bring your Medicaid card with you to your appointment. If the patient is not eligible for Medicaid, at the time of service, then the patient will need to pay before services are rendered. **This payment will not be refunded if retroactive coverage is obtained.**
Newborns	We can use mother's Medicaid card. Once child has been reported to case worker a Medicaid number will be assigned in child's name and date of birth.
Private Insurance	As a courtesy, our office will file your insurance for you, but ultimately the responsibility of payment is yours.
Collections	Accounts turned over to a Collection Agency will receive a dismissal letter from our office and will incur a **$25.00** administrative fee as well as any additional fees associated with that effort, including court cost.
Other Information	Any check returned to our office for non-payment will generate an additional processing fee of **$25.00.**

My signature below certifies I have read and understand/accept the terms of the Financial and Collections Policy as stated above. I agree and understand that the office of Blue Ridge Pediatrics, LLC., will file my insurance for services rendered.

______________________________ ______________________________ ______________

Parent/Guardian Name (Please Print) Parent/Guardian Signature Date