Children's Mercy-Premier Pediatrics
8675 College Boulevard, Suite 100
Overland Park, KS 66210
913-345-9400 - Office
913-345-9408 - Fax

PAYMENT POLICIES – EFFECTIVE JULY 2026

Thank you for choosing CM-Premier Pediatrics for your child's medical care. We are providing you with the following information to help you understand our insurance and billing policies.

YOUR RESPONSIBILITIES:

- **Credit Card on File:** Due to the ever-increasing changes in the structuring of insurance plans and patient responsibility associated with such, **we require all parents to leave a credit card on file with our office**. **If you do not provide a credit card, you will not be seen**. If your credit card declines and we cannot collect payment, you will be subject to a $25 fee. The card number will not be stored on our computer servers, rather encrypted off site at InstaMed Secure Data Centers.

- **Payments: You must pay your co-pay at the time of the office visit**. Our contracts with **the insurance companies require us to collect the co-pay at the time of service**. If your insurance doesn't validate in our system with a co-pay, but later processes with a co-pay, the card on file will be charged for that amount. Returned Checks/Insufficient Funds will have an additional $35 charge to the account.

- **Chargebacks: You will incur a $35 fee for any chargeback that is reversed in favor of Children's Mercy - Premier Pediatrics, Inc. We encourage you to call our office if you have questions regarding your account.**

- ***Vaccines: Once you verbally agree with the provider on vaccines, they will be prepared and you will be financially responsible for them.***

- **Insurance Plan: You must show your current insurance card at every visit.** It is your responsibility to confirm with your insurance company that the physician is currently under contract with your plan or be willing to be seen as "out of network." You are also responsible for knowing where your insurance requires you to go for any lab or radiology procedures. Any questions about medical, well baby/preventative care, labs/x-rays and immunization coverage should be directed to your insurance carrier prior to your visits. You are responsible for all co-pays, deductibles and non-covered services determined by your insurance plan. If we cannot validate your coverage, we may assign your account to self-paid status and request full payment at the end of your visit.

  Your insurance policy is a contract between *you* and your insurance company, even if your employer provides it. If your insurance plan requires you to choose a primary care provider, you must contact your carrier and select one of our providers as soon as your medical records are transferred. In accordance with carrier guidelines, we cannot schedule any appointments or write any referrals until we receive notice that you have added one of our providers as your primary care physician.

- **Deductibles & Co-insurance: We submit claims to your insurance company after your visit. Once the claim is processed, they will send an Explanation of Benefits (EOB) to you and they will inform us of any patient responsibility. If a patient balance is not paid, or a payment plan is not established within 30 days of receiving a statement, the card on file will be charged. If you would like to set up a payment plan, or have any questions about your account, please call our Billing Office. If the card on file is declined, a $25.00 fee will be applied and we will send a statement and a non-payment letter.**

- **Non-Contracted insurance carriers or share policies:** We will expect payment, in full, from you at the time of service and it will be your responsibility to submit any claims to your insurance company for direct reimbursement to you. We will provide you with the appropriate information to assist you in the process.

- **Newborns:** Birth and adoption may trigger a special enrollment period during which you, your spouse, and your dependents can enroll in your employer's plan or in a plan offered through the Health Insurance Marketplace. To request special enrollment in an employer plan, **you much notify your plan within 30 days of your child's birth, adoption, or placement for adoption.**

- **Collections:** Accounts over 90 days past due will be sent to RHS Collection Agency. If your account is turned over to the collection agency, you will be dismissed from the practice. Once an account is placed with the collection agency, a ***30% collection charge*** will be added to cover the collection fees. The practice will try to work with you to avoid being sent to the collection agency.

    - **If your claim is denied, we will contact you to resolve the situation before collecting any amount owed for non-covered services.**

- **Divorce or split family situations:** Charges due will be charged to the credit card on file. If a statement is required for billing, it will be sent to the guarantor. The guarantor is defined as the parent/person who provides the primary residence for the child. The guarantor can be different than the main insurance policy holder. The guarantor is the "primary" contact that is pulled from registration. If the guarantor believes a former spouse is responsible for the balance, the guarantor must forward the statement to him or her.

- **"No Show" and "Same Day Cancellation" Fee:** A $50.00 "No Show" or "Same Day Cancellation" fee will be assessed if an appointment is not attended and not cancelled 24 hours prior to the appointment. If a second "No Show" or "Same Day Cancellation" occurs in the same calendar year, the fee will increase to $75.00. If a third "No Show" or "Same Day Cancellation" occurs in the same calendar year, the fee will increase to $100.00 and a letter will be sent to the family outlining our "No Show" and "Same Day Cancellation" and the potential for dismissal from the practice. The fee will also include appointments that are for immunizations scheduled with a nurse and flu shots whether given during our flu clinic or scheduled during the week.

Patient Name: _____ DOB_____

Patient Name: _____ DOB_____

Patient Name: _____ DOB_____

Patient Name: _____ DOB_____

Patient Name: _____ DOB_____

Patient Name: _____ DOB_____

(Please list all family members with first and last names seen at Premier Pediatrics)

By signing below, I acknowledge understanding of all of the policies listed above.

PRINT NAME (first and last): _____

Signature: _____ Date: _____

(Signature of parent or legal guardian if patient is less than 18 years old)
(Signature of PATIENT if over 18 years of age)

This Financial Agreement is Effective for 2 Years from Date Above)