

PEDIATRIC HEALTH ASSOCIATES, P.C.
FINANCIAL POLICY ACKNOWLEDGEMENT

CHILD'S NAME: _____ **BIRTHDATE:** _____

Thank you for choosing Pediatric Health Associates as your child's health care provider. The following information will help explain our financial policies so you understand the issues involved in paying your medical bills. As we enter this doctor-patient [parent] relationship, we agree to provide you with quality medical services at a fair and reasonable price, and you agree to be prepared to pay at the time of service, and/or to understand your obligations with your insurance plan.

ADMINISTRATIVE REQUIREMENTS: We require all new patients to complete a *Registration Form*, *Financial Policy*, *Medical History Form* and *Communication Consent* when they arrive. The *Registration Form* and *Medical History Form* will be updated on a yearly basis. These forms are also reviewed on a visit-by-visit basis, regardless of changes.

Since most of our patients are children under 18 years of age (minors), the parent, guardian or personal representative accompanying the minor is responsible for any payment due at the time of service. Our staff will not get involved in negotiating responsibility between parents in custody or legal disputes. We require a *Medical Consent Authorization* before any services will be rendered to a child not in the presence of their parent or guardian.

LATE, MISSED OR CANCELLED APPOINTMENTS: When an appointment is scheduled, this time is reserved for your child. Please arrive 15 minutes prior to your appointment. If you need to cancel or reschedule an appointment, we request that you notify our office 24 hours in advance. If your appointment is made the "same day" and you are unable to keep it, cancellations are required at least 1 hour prior to appointment time, so another child can be scheduled. Our policy is to charge a \$25.00 no-show fee on the 3rd missed appointment. This fee will only be waived for documented medical emergencies. This fee is not payable by insurance and must be paid before your next appointment is scheduled. Patients that arrive more than 15 minutes past their appointment time will be asked to reschedule at the discretion of the doctor. Patients with 4 missed appointments within 12 months will be charged \$25.00 and asked to transfer their records. New Patients who fail to arrive on their scheduled visit will automatically be discharged from the practice. Please help us serve you better by keeping scheduled appointments.

PAYMENT REQUIREMENTS: Copays are collected when the patient registers with our receptionist. If a copay is not paid within 5 days, a \$5.00 unpaid copay fee will be assessed to the account. You will also be asked to pay any balance over 30 days old. There is a \$45.00 after-hour charge for emergency visits on Saturday appointments. We accept cash, personal checks (with photo identification), Visa or MasterCard as a form of payment. For our credit card customers, *Express Check-Out* is available. If for any reason a payment is missed at the time new services are being rendered, you will be asked to complete a *Missed Payment Form*.

If you **DO NOT HAVE INSURANCE**, full payment is expected at the time of service. A 15% discount will be offered. This discount is void if the balance is not paid in full at check-out. If the balance is not paid within 5 days, a \$5.00 fee will be assessed to the account. Special payment arrangements require prior approval and an appointment with our collection assistant or Practice Manager to discuss your circumstance. Your child may be eligible to receive free vaccines, but all subsequent charges for office visits and administration fees remain your responsibility.

There is a \$30.00 returned check fee assessed to all accounts when a bank returns a check to us for insufficient funds. If the returned check is not paid within 10 days, Pediatric Health Associates will assign the account to the local district court for collection. You agree to be financially responsible for all court fees incurred to collect the bad check and waive all confidentiality due to public records. Any future payments to our office must be in the form of cash or credit card.

An itemized statement listing your child's services will be sent to you when the Explanation of Benefits is received from your insurance plan. Any outstanding balance is due within 30 days of the statement date. All subsequent statements will be assessed a \$5.00 re-billing fee. Regardless of insurance, payment remains your responsibility whether they pay or not. All balances that reach 60 days past due will be placed in collections. Should your account be sent to an outside collection agency, you will be financially responsible for all collection and legal fees incurred to collect the delinquent balance and waive all confidentiality due to public records. A 35% collection fee will be applied to all delinquent accounts. **All balances must be satisfied prior to any future appointments.** If the collection balance is not paid within 6 months, the account will be closed and the family discharged from the practice. Help us keep the cost of medical care down by eliminating the need for us to bill you.

Parents are responsible for making sure newborns are added to your insurance policy as soon as possible. If you do not provide us with insurance information within 30 days, we will consider your account to be self-pay / no insurance. At that point, you will be required to make payment within 30 days or be subject to billing fees and collection efforts.

INSURANCE: Please ask for a copy of our insurance participation list. Insurance cards must be presented at every visit to ensure accurate billing information is obtained during registration, regardless of participation. If you do not have your card or we can not verify your benefits at the time of service, you will be asked to complete a *Guarantee of Payment Form*.

We must emphasize the importance of understanding that your insurance policy is a contract between you and your insurance company, and as pediatricians, our relationship is with you, not your insurance. Not all services are covered under all insurance plans. It is your responsibility to know what coverage your plan provides. If you are unsure, please contact member services at the telephone number on your identification card. Due to "timely filing deadlines" on insurance contracts, if incorrect insurance billing information is given to Pediatric Health Associates, the patient will be responsible for the balance and a \$5.00 billing fee will be assessed to the account.

If we DO participate with your insurance plan, all services performed in our office and at the hospital will be submitted to your insurance as a courtesy to you. If we obtain prior notification of non-covered services, deductibles or coinsurance, the amount due will be collected by our check-out secretary. If these amounts cannot be determined ahead of time, our office will bill you. Most insurance contracts state that your balance must be paid within 60 days of the date of payment. If not paid by this deadline, you will be responsible for the amount that would have been "disallowed" according to our participation agreement. If your insurance claim is not paid within 45 days of submission, the balance becomes your responsibility unless other arrangements have been made. If your insurance plan does not cover immunizations, we can provide the address and phone number of a local clinic that can provide these services for a nominal charge.

If we DO NOT participate with your insurance plan, you will be asked to pay in full at the time of service. Once paid, claims will be submitted to your insurance as a courtesy. We can also provide you with an itemized statement for submitting your own claims to your insurance plan for reimbursement. This means the insurance plan will send the payment directly to you. If we receive the insurance payment, a refund will be processed in a timely manner. We will not accept counter-signed insurance checks as payment in full for the services rendered. If you have any questions, please contact our business office. They will be happy to assist you.

If you have an HMO that requires a referral for any services performed in or out of this office, it is your responsibility to request and obtain a referral 48 hours prior to the date of service. If a referral is not presented at the time of service, the patient will be requested to sign a waiver and assume financial responsibility for that service.

UCR (Usual and Customary Rates): Our practice is committed to providing the best medical care possible. We charge what is usual and customary for our area. You are responsible for payment regardless of any arbitrary determination of usual and customary. All insurance plans have fee schedules from which they pay, however, our fee schedule may be more or less than what your insurance plan pays. Therefore, any balance not covered by the insurance plan becomes the responsibility of the patient.

MEDICAL RECORDS & FORMS: There are fees associated with copying medical records and completing specialty forms. Please ask our Health Information Coordinator or Practice Manager for assistance.

We appreciate the time you have taken to read and understand our financial policies. We welcome the opportunity to discuss any part of it with you. If you have questions, please do not hesitate to ask our front office staff for assistance. You can also call our business office with any insurance or payment questions at (717) 755-6260. We ask that you please keep your records current and notify us as soon as possible if your address, phone number, insurance or employment has changed.

Thank You! We look forward to a long healthy relationship.

I have read and fully understand the financial policy set forth by Pediatric Health Associates and agree to the terms. I agree that these policies are a condition of receiving care. I understand that the terms of these policies may be amended by the practice at any time without prior notification.

Signature of Parent/Guardian/Personal Representative (SEAL)

Date