

Thank you for choosing us as your health care providers. The following statement is our financial policy. Your agreement to this policy is required prior to any treatment. The parent or legal guardian is responsible for payment at the time of the visit.

Please acknowledge each statement below by initialing on the line.

Payment

- _____ Payments are due at time of service, this includes, self-pay, co-pays, deductibles, non-covered and out-of-network services. Our staff attempts to estimate any deductible or coinsurance balance due at the time of visit, but you will receive a final bill after your insurance as processed the claim if there is a remaining balance due after the estimate at date of service.
- _____ We accept VISA, MASTERCARD, cash or checks. Positive ID is required for all credit card or check payments. There is a **\$50.00** fee for all returned checks. We do accept payment online thru our website.
- _____ Patients that pay in full at the time of service will receive a 25% discount. You may then file a claim directly with your insurance company.

Insurance

- _____ It is your responsibility to ascertain that your medical provider is a participating provider with your insurance company.
- _____ If we are not in network with your insurance company, you are responsible for the balance due after we have filed the claim and non-network benefits are applied to balance due by the patient.
- _____ A current insurance card and positive identification is required at each visit. Failure to provide the required information will result in forfeiture of the scheduled appointment unless cash or credit card payment can be made for the total charges of the visit.
- _____ You are responsible for verifying benefits and coverage prior to any visits so that you are not billed for unanticipated charges. Some insurance companies do not cover some routine and non-routine services. Non-covered services will be billed directly to the patient. (Common exclusions: Well Visits; Immunizations, Hearing Screens; Vision Screens; and After Hour Phone Calls.)
- _____ Please be aware that your health insurance plan may not consider discussion of additional acute or chronic conditions or significant problems as part of your child's well-check exam, which will focus primarily on preventive treatment. Discussing additional issues and/or symptoms of another medical condition in a preventive well-check exam can create another office visit fee and would result in additional charges and a co-pay or deductible/coinsurance amount depending on your health insurance plan. Any charges not considered as part of the routine well child exam must be billed out as a separate code and you may be billed for those additional services. Questions about your benefits should be directed to your insurance plan or your employer's Human Resources department.
- _____ All outstanding balances that have not been paid within 60 days will be billed to the patient and must be paid by 90 days of date of service regardless of the insurance status. **Unpaid patient balances older than 90 days will be turned over to our collection agency. A collections charge will be accessed for these documents.**

Child Custody

- _____ In cases of separated or divorced parents, custody or legal issues, the guardian insuring the child at the time of service will be deemed the responsible person. NAPPA statements will be billed out to the adult insured listed on the patient's account. Our office will not get involved in disputes related to parent responsibility of account. We understand the family dynamics can be delicate, please do not expect our staff to mediate financial obligations or any communications between our office and a patient's guardian. If there are legal documents reflecting in judgement changes, we must have copies of those on file in the patient's chart. The billing procedures as stated above apply to the patient's account and splitting of balances due and payments made must be handled and communicated thru the patient's parents, not our staff.

Late Arrival of Appointments

- _____ Arrival of an appointment time later than 15 minutes will be rescheduled unless the Provider's schedule allows for the tardiness and the patient can be worked back into the schedule.

Missed Appointments

- _____ We attempt to make reminder calls for well visits, but it is ultimately your responsibility to remember appointments. Cancellations require 24-hour prior notice. Cancellations with less than 24-hour notice and missed appointments will be assessed at \$50.00. Please schedule well checks at least one month ahead.

(over)

After Hours phone calls/Saturday Appointments (Monday- Friday AFTER 4:30pm, weekends, and holidays)

_____ There is a **\$35** charge for after hour doctor call consultations and a **\$25** charge for nurse calls provided by Triage 4 Pediatrics. We will bill you for this charge for which you may then file a claim with your insurance company if this is a covered service under your policy.

_____ If you are seen in the office on a Saturday/Sunday there is an additional charge of \$40.00 that may or may not be covered by your insurance.

I have read and understand the above financial policy and I understand and agree to its terms and allow North Austin Pediatrics, P.A.'s medical providers to treat my child:

I, _____ **have received a copy of this document.**
PLEASE PRINT NAME

X _____ Date _____
SIGNATURE OF PARENT