

Pediatric Associates of Greater Salem
PATIENT FINANCIAL POLICY, Effective September 1, 2008

PCC # _____

Patient: _____

Thank you for choosing Pediatric Associates of Greater Salem for your health care provider. Payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy: FULL PAYMENT OF PATIENT OBLIGATIONS IS DUE AT TIME OF SERVICE.

It is the policy of this office to help keep your health care costs as low as possible. To do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

- Always bring your current health insurance card to the office.
- Notify us of any changes in insurance, address, telephone, or family status at time of check in.
- Pay your co-pay or deductible balance and co-insurance amount at the time of service.
- You will be expected to pay in full if
 - You do not have insurance;
 - Our practice does not participate with your health plan;
 - You are unable to present a valid member identification card from your insurance carrier at your visit; or
 - We are unable to verify your insurance coverage.

You should receive a bill for any other patient responsibility within 30 days, and/or an explanation of benefits (EOB or EOP) from your insurance company. If you fail to receive an EOB or EOP from your plan within 45 days of treatment, we suggest you contact your insurance plan to determine benefits, as they may not have made payment. Payment not received in 60 days may be transitioned to patient responsibility and you may be required to make other payment arrangements.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan and you will be 100% responsible for these charges. The following are your responsibilities:

- Ensure our providers actively participate with your insurance carrier.
- Know your and your dependents benefit coverage, prior to receiving services.
- Make sure that all individuals on your policy have the correct primary care physician selected at your insurance company as this is the number one reason why claims are denied.
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Remember that we must receive your billing information at the time of each visit in order to meet the claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.

We will not be held liable for ensuring the accuracy of your insurance information, including, but not limited to, verifying current coverage and eligibility, obtaining authorizations, or confirming co-pay, coinsurance, and/or deductible information. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

To summarize, your financial responsibility retains to

- Denied and non-covered services;
- Services deemed not medically necessary by your insurance company;
- Co-payments, deductibles, and co-insurance;
- Pended claims due to lack of patient and/or guarantor information;
- Non-Insurance and/or out-of-network benefits.

CO-PAY, COINSURANCE: We are required by our insurance contracts to collect all co-pays and other patient responsible amounts at the time of service. We may request a deposit of \$25.00 prior to your being seen by a physician.

CO-PAY SURCHARGE: Any co-pays that are not paid on the day of the visit will be subject to a \$10.00 co-pay processing fee. To assist you, we accept cash, checks, credit cards, or debit cards.

DEDUCTIBLES: If you have not met your deductible, we will estimate the expected insurance payment for your visit and request that amount at check out. You may receive a statement with additional balances after your visit. We may also request a deposit prior to your being seen by the physician of \$75.00 for new patients and \$50.00 for established patients.

SELF-PAY PATIENTS: Self-pay patients are required to make a deposit of \$50.00 at the time of service during check in. If additional charges are accrued, you must pay for the charges before leaving the office.

RETURNED CHECKS: There is currently a \$25.00 fee for any checks returned by the bank. We have the right to adjust this amount any time.

MISSED APPOINTMENTS: Unless canceled at least 24 hours in advance, our policy is to charge \$35.00 for missed appointments. There may be an additional fee for missed physicals. We will not file, nor will insurance plans pay for this charge, so please help us serve you better by keeping, or canceling in advance, scheduled appointments.

COLLECTIONS: Failure to pay account balance within 30 days from initial billing may result in interest charges up to the maximum legal amount allowed by law. Any past due balance not paid will be turned over to a collection agency after 90 days. Any charges and fees resulting from this action, including collecting agency fees, will be added to your account balances and will be your responsibility. In the event that the bill remains unpaid and litigation ensues for collection of sums due, this office shall be entitled to reasonable attorney fees and court costs.

LAB/X-RAY/DIAGNOSTIC SERVICES: You may receive a separate bill for medical care which includes lab, x-ray, or other diagnostic services from another facility. You are financially responsible for any co-pay or balance due for these services if they are not reimbursed by your insurance.

STATEMENTS: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment or credits applied to your account during the month.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within ten days.

PAYMENT OPTIONS IF YOU HAVE NO INSURANCE: Unless arrangements are made in advance, we will collect payment at your visit. Your choice is to pay by cash, check, or credit/debit card on the day that treatment is given.

INSURANCE RELEASE: You understand that your health plan may not be liable for service rendered if any of the following conditions apply:

- You have a pre-existing condition or other diagnosis that may not be covered by your plan;
- Our practice does not participate in your health plan;
- You have not met the deductible under your health plan contract;
- Well child check-up, immunizations, adult or sports physicals, as well as other routine services, may not be covered by some insurance plans.

DIVORCE: In case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect funds from the other parent.

ON-THE-JOB INJURIES/ACCIDENTS: If the reason for your visit is an accident or injury while on the job, please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier. *The bill will not be covered unless your employer files a claim to the carrier* – it will remain your responsibility until a valid claim is filed by your employer.

COPIES AND TRANSFER OF RECORDS: You may be charged a base fee of \$15.00 for each transaction. Additionally, we may charge up to \$0.50 per page for the copying costs of the first 100 pages of medical record, and \$0.25 per page in excess of 100 pages.

EFFECTIVE DATES: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect.

I have read and understand Pediatric Associates of Greater Salem's Financial Policy. I agree to assign insurance benefits to Pediatric Associates of Greater Salem whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for the cost of collections.

Signature of insured or authorized representative: _____ Date: _____