SPRINGVILLE PEDIATRICS

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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.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. 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 and verify your eligibility, prior to receiving services.
- Know your co-pay, coinsurance, and/or deductible amounts.
- 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-authorization requirements are met to avoid denials or out-of-network benefits.
- You will be considered self-pay for the day's visit 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.

INSURANCE BILLING: Remember that we must receive up to date billing information in order to meet the claims submission guidelines set by your insurance plan. If you fail to provide complete and accurate primary and/or secondary insurance information on the date of service, you will be held responsible for services rendered that day.

If we are not a participating provider with your insurance plan or if your insurance plan does not provide coverage for the provider you are seeing, you will be 100% responsible for all charges incurred and will be considered self-pay for all visits.

To summarize, you are financially responsible for

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

CO-PAYS: We are required by our insurance contracts to collect all co-pay and patient responsible amounts. Co-pays are due at the time of service. If you do not know your co-pay, we may request a deposit of $25.00 prior to your being seen by a physician.

DEDUCTIBLES: If you have not met your deductible, we may request a deposit of $75.00 prior to your being seen by the physician.

SELF-PAY PATIENTS: Self-pay patients are required to make a deposit of $75.00 during check-in. If additional charges are accrued during the visit, you must pay for the charges before leaving the office.

NON-EMERGENCY APPOINTMENTS: Well child visits, physicals, or any non-emergent follow-ups or visits may be rescheduled if outstanding balances, co-pays, or self-pay charges are not paid at the time of service.

RETURNED CHECKS: The current fee for returned checks is $30.00. We have the right to adjust the amount at any time.

CHILD CUSTODY: For any children seen, the accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital custodial disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and non-custodial parent.

STATEMENTS: We will send monthly statements for charges that have been identified as your responsibility. Your monthly statement will separately list previous balances, 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 30 days of the statement date.

COLLECTIONS: Failure to pay account balance in full within 30 days from statement date may result in a $5.00 rebilling fee to cover the cost of mailing additional statements. Any past due balances not paid after 120 days from initial statement date will be turned over to a collection agency. You will be responsible for any charges and fees resulting from this action. If your account should be forwarded to a collection agency, we will continue to see you on an emergency-only basis for 30 days, allowing you time to find a new source of medical care.

SLIDING FEE SCHEDULE: We offer discounted service rates for eligible patients who wish to apply. These rates are based upon your annual household income. To determine eligibility, we will need to see proof of identification and address, three most recent pay stubs, and evidence of Medicaid program rejection.

PAYMENT PLANS: We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office promptly for payment arrangements and assistance in the management of your account. We do offer a limited payment plan for those patients who need some flexibility, with the following criteria:

1. You will be required to provide us with a credit or debit card number to automatically process your payment on specified dates.
2. The balance must be paid in full within six months of the date of a signed payment plan agreement (unless otherwise specified).
3. A copy of this agreement will serve as your reminder. Regular statements will not be mailed for this balance.
4. No future charges may be added to this payment plan, as it is not intended to be a revolving charge account. Until the initial payment agreement is paid in full, all future visit costs will be due in full at the time of service.
5. If at any point you are unable to keep this payment agreement, and fail to notify Springville Pediatrics, your account will be sent to a collection agency. If your account is forwarded to collections, you will be given 30 days to select a new primary care physician. During that 30-day period, we will continue to provide emergency-only medical care for your child.

COPIES OF MEDICAL RECORDS: Per state law, you may be charged up to $1.00 for each page of the first 25 pages, $0.50 for each page in excess of 25 pages, and a search fee of $5.00 for each patient health record requested.

I have read and understand Springville Pediatrics Financial policy. I certify that I have provided Springville Pediatrics with complete and accurate insurance coverage information, and I understand that I am financially responsible for all services or fees regardless of insurance coverage. I further authorize the release of necessary information in order for Springville Pediatrics to receive payment for services.

Signature of Guarantor: _____ Date: _____