CHILDREN & TEENS MEDICAL CENTER
Financial Policy

www. Childrenandteens.com

Please be assured that everyone in this practice is dedicated to providing medical care of the highest quality possible to all of our patients, in an atmosphere of caring, trust and mutual respect.

Your complete understanding of your financial responsibilities is essential; it takes a team that includes patient participation, to succeed with insurance processing and reimbursement. Failure by the insurance company to pay, results in the balance being transferred to the patient for payment.

Our practice policy requires that prior to any services being rendered; all patients must sign the practice financial policy.

In order to become a "provider" of medical services through your health plan, the physicians at Children & Teens Medical Center are required to enter into a contract with selected insurance companies. Many such contracts stipulate that the physicians will not provide or charge for "unnecessary medical service," as determined by the insurance companies. Past experience has shown that some "health plans" have very different ideas than members, such as yourself, with respect to what is or is not "medically necessary".

This asserts your conviction that the described services rendered are appropriate and "necessary" as far as you are concerned, irrespective of the determination of your insurance company.

In the more recent years it has become increasingly difficult to collect the fees rightfully due to the provider for services rendered, in good faith, to their patients. To this end we have found it necessary to be very explicit in our financial polices of this practice. All too often we are finding patients presenting to the office stating they have no form of payment for the services they are about to receive. Please come to the office with a form of payment to meet your obligations to your insurance provider and to your healthcare provider.

We thank you in advance for taking the time to review these policies and your understanding of our need to have in place such an in depth policy. Please feel free to discuss any concerns or questions you may have with anyone of our billing staff or our practice administrator. We would welcome the opportunity to assist you in your understanding the complexities of health insurance today.

Things to bring with you to your visit:

- Health Insurance Card – we are required to verify these with a government approved form of ID.
- Drivers License or Government Identification Card
- Method of payment – for your convenience we accept Visa, MasterCard, Discover and cash.

Acknowledgement of Receipt of Privacy Notice:

I have received and/or have been presented an opportunity to review the Children & Teens Medical Center Privacy Notice. I understand that I may obtain an office copy of this notice and any future revised notices on the Children & Teens Medical Center website. (www.childrenandteens.com)

Assignment of Benefits:

- Children & Teens Medical Center will only bill contracted insurance plans as a courtesy to our patients provided that the patient has provided the required insurance information in a timely manner and has signed a current financial policy.

Appointment cancellation, rescheduling and no-shows

- Your appointment will be confirmed by our office 48 hours before your appointment, as well as a reminder email from the patient portal. This will help to remind you to cancel and re-schedule your appointment within the 24 hour notice should you need to. We do offer a waiting list for patients who would like to be seen sooner than the appointment we were able to schedule for them. Patients calling us and cancelling *prior to* 24 hours, allows us to accommodate other patients that may be on the waiting list.
- If you do not show for your appointment, cancel or reschedule *prior to* 24 hours of your appointment time, we will send you one reminder notice of this policy. On the second occurrence we will bill you an administrative fee of $50.00. On the third occurrence we may require a $50.00 deposit at the time you schedule your next appointment.

Additional Testing:

- For preventative care exams the physician may request your child (ren) to undergo certain additional screening tests. Please contact your insurance company to determine if these are covered benefits to avoid incurring charges for which you MAY/ will be held responsible:

2 week, 2, 4, 6, 9 month exam Maternal Post-partum Depression Screening Questionnaire
9, 18 and 12 month Ages & Stages Developmental Screening Questionnaire
6 mo to 4 years: screening lab work (Lead, HGB, glucose)
12-18 years: Adolescent Depression Assessment, pap testing, screening lab work (CBC, CHEM, TSH, CRP, gonorrhea, Chlamydia).

Consent for Treatment: As the legal guardian(s) and/or custodial parent(s) of your children, it is acknowledged that in presenting the child(ren) for treatment and continuing medical care at any Children & Teens Medical Center (CTMC) facilities (aka my child/children's Medical Home), that I authorize and consent to the administration and performance of all tests and treatments which may be ordered by the physician and/or nurse practitioners and carried out by the members of the Children & Teens Medical Center medical staff and personnel. (Includes but is not limited to, same day well exam and acute appointments, screenings, durable medical equipment, lab procedures done by the physician and/or nurse practitioner).

Cash Pay/Fee for Service:

- We offer a discount on our office exams for our cash pay/fee for service patients who have no health insurance coverage in any form.
- Prior to your visit, you will be provided an estimate of the visit cost and will be required to pay in full at time of check in on the day of your appointment. In the event your provider carries out additional procedures/tests, you will be required to pay for these at the time of check out.
- You will be asked to sign a waiver stating that you have no health insurance coverage and will not be filing with any health insurance carrier.

Charges for copies of medical records:

- You will be charged for copies of medical records as per Medical Association, State and Federal guidelines. These charges cover the administrative costs of copying and mailing such records.
- If you have signed up for the patient portal, immunizations and patient summaries are available to you at no cost. Any additional copies will require you to complete a request of medical records form. Payment is required prior to the release of records.

Co-pay and co-insurance:

- We are obligated to collect the co-pay at the check-in time of your visit, even if you are sick. We are required to do so by your insurance plan. The co-payment amount is determined by your individual insurance policy. If you receive two different types of services on the same day, you will be asked to pay two co-pay amounts if required by your insurance plan.
- All payments are due at time of service.

Credit Card Policy:

- You will be asked to review, and sign our credit card on file policy and authorization form. (The same process you would go through for hotels, rental cars etc.)
- Your credit card will be billed for fees not covered by your insurance at the time we receive the EOB back from your insurance company that indicates that the patient is responsible for the remaining balance.
- At the time we do this, you will receive an email notifying you within 24 hours that your credit card will be used for the payment. You will also receive a receipt via email.
- Will be used within 12 months of date of service.

Deductibles:

- Some insurance plans require that patients pay a predetermined dollar amount prior to services being covered. If verification of your deductible is unable to be made, payment of the full deductible is due at time of service.

Filing Secondary Insurances:

- We will file charges with your secondary insurance carrier as long as the information has been given within the timely filing insurance limits per your insurance carriers' determination period.

Financial Hardship:

- For patients who are suffering financial hardship and are suggesting they are unable to pay for their healthcare, you will be required to prove such hardship and provide documentation per OIG (Office of Inspector General) guidelines and assessment made in relation to the current HHS poverty guidelines, before a financial arrangement can be agreed upon.

FMLA and other Disability Paperwork:

- There is a charge of $20 per form, payable prior to these forms being completed. Please allow the office 10 business days in which to review your medical record for the information requested, to be completed, copied and mailed or faxed.

Health Savings Accounts / Healthcare Debit Cards:

- These cards carry a high deductible and you are responsible for payment of all healthcare services in full, at the time of service. If we are contracted with the health insurance with which you have this kind of plan, we may only bill you the full amount of our contracted allowable fee.
- We ask that you do not ask us to bill you for services rendered, we will require payment in full at time of service.

Hospital Admission related bills:

- Our fees do not include these services or service rendered by the hospital or other attending physicians during any hospital treatment or surgery.

Insurance:

- We are contracted with multiple insurers to accept assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the authorized co-payment, co-insurance and deductible at the time of service.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a cash pay patient and will be provided documentation to assist you in filing your claim
- Failure to notify the office with insurance changes or presenting without an insurance card may result in rescheduling of your appointment. If we are unable to verify your benefits should you have new insurance at the time of checking in for your appointment, you will be required to pay for your services at the time of visit.
- We are required to file with your primary insurance carrier only. It will be your responsibility to pay any balance not covered by the primary and file with your secondary insurance carrier.

Laboratory and other diagnostic services bills:

- Please check with your insurance company to verify what your schedule of benefits allows for any laboratory, Durable Medical Equipment such as, splints, casts, nebulizer masks and tubing or other diagnostic studies (PFT-pulmonary function testing) that may be ordered by the doctor during your visit. Any insurance claims or problems associated with an off-site laboratory (ACL/Quest) must be dealt with through that laboratory facility or their billing agent.

Medicaid Patients:

- Please do not ask to be seen under Medicaid if you have other health insurance. You must be seen under your primary insurance. You will be asked to sign an insurance waiver stating that you have no other coverage and in the event it is determined that you do and your claim is denied by Medicaid for this reason, you will be responsible for your bill in full.
- Please ensure that you bring your Medicaid card to every visit.
- In the event you do not bring your card, your visit will need to be re-scheduled until such a time that we have proof of your Medicaid eligibility and cover.

Non-Sufficient Funds (NSF check):

- A $30.00 charge will be added to your account for any NSF checks returned for any reason from your bank.

Out of Network:

- Full payment is due at time of service.
- Appropriate claim documentation will be provided for filing with the insurance company.

Outstanding balances/ Collections:

- Prior to providing additional services to you, payment in full of total outstanding balances will be required.
- Patients with unpaid delinquent account or accounts which have been sent to collections and written off to bad debt MAY be discharged from the practice.
- Outstanding balances that are greater than 45 days old will be referred to an outside collection agency. Once we receive an EOB (explanation of medical benefits) from your insurance, we will mail to you a statement. If we do not receive payment within 45 days, your account will be referred to a collection agency.

Patient Responsibility:

- Minor Patients: For all services rendered to minor patients, we will look to the accompanying adult or custodial parent or guardian, for payment. We will not disclose any confidential information to the parent or guardian without written authorization from the minor.
- Understanding of benefits: It is the parent/patient's responsibility to call their insurance company and find out what your schedule of benefits allows and what services they will and will not cover.

Payment Responsibility:

- The patient or her legal representative is ultimately responsible for all charges for services rendered.

- "Non-covered" means that a service will not be paid under your insurance contract. If non-covered services are provided, you will be expected to pay for these services at the time they are provided, or at the time of receiving a statement or EOB from your insurance provider denying payment.
- Appeal procedures are generally available, and we will be happy to assist you in trying to "overturn" an adverse determination. **We will not under any circumstances falsify or change a diagnosis or symptom in order to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered.** We cannot offer services without expectation of payment, and if you receive non-covered services, you must agree to pay for these services in the event that your insurance company does not.
- If you are unsure whether a service is covered by your plan, ultimately it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.
- A $10.00 rebilling fee with be charged on accounts over 45 days old.

Phone Appointments:

- If you need to discuss a healthcare issue or abnormal test results, you will be asked to schedule an appointment to see your provider.

Referral for Outside collection:

- Accounts which have not been paid according to the financial policy will be referred to an outside collection agency/attorney for further action.
- The patient's care with Children & Teens Medical Center may be terminated and the patient may be required to seek an alternative medical provider.

Refunds:

- Refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full. Refunds less than $10.01 will not be issued unless requested.

Uninsured patients:

- Payments for all services rendered are due at time of service. Please complete the Patient Eligibility Screening Record for children under the age of 18 years in order to receive state required immunizations at a discounted rate.

Well child visit and Problem/sick visit on the same day:

- Some insurance companies will cover well-child/preventative visits and some will not. It is your responsibility to know what healthcare benefits your insurance covers, prior to your visit. If you need to discuss any health problems that require evaluation and management, this must be documented and appropriately billed for. Your insurance company may not pay for these additional problems that are addressed during the well-child/preventative exam. Your insurance company may charge a co-pay, co-insurance or deductible for the second visit and you will be responsible for any additional costs that this second visit may occur.

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Signature