

## **ROSWELL PEDIATRIC CENTER, P.C.** **FINANCIAL POLICY**

We are committed to providing your child with the best possible medical care. If you have special financial needs, we are willing to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. **We will file insurance as a COURTESY; however, YOU ARE ULTIMATELY RESPONSIBLE FOR YOUR CHILD'S CHARGES.**

1. Our office participates with a variety of insurance plans.

**It is your responsibility to:**

- **Bring your insurance card and photo I.D. at every visit.**
  - **Pay your Co-Payment and/or any deductibles at each visit.** Payment can be made by cash, check or credit card. We accept VISA, MasterCard, and Discover. We do not bill for Co-Payments.
  - **Pay in full for any medical care or services that are not covered by your insurance plan.**
2. If your child has insurance that we do not participate with, or your child does not have insurance, payment in full is expected at the time of service. Your child will be a "Private Pay" patient in our office. We offer a discount to "Private Pay" patients, if the charges are paid at the time of service. "Private Pay" patients receive a 20% discount on Sick Visits and a 40% discount on Well Care Visits (other than Vaccines).
  3. If your insurance plan is a HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice. If your insurance card lists another physician's name, we will see your child, but you will be "Private Pay" and required to pay at the time of service until the PCP has been changed to one of our physicians.
  4. **Secondary Insurance:** We do not file secondary insurance. You may request a copy of the claim to file your child's secondary insurance yourself.
  5. **You are financially responsible for any amount not covered by your child's plan.**
  6. **You are financially responsible for all charges incurred in your child's care and treatment.**
  7. If you have questions about your insurance, we are happy to help. However, specific coverage issues should be directed to your insurance company member services department. The telephone number is usually located on your insurance card.
  8. If you fail to make payment in full for services that are rendered to you, your outstanding balance will be sent to an outside collection agency. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
  9. To protect your child's records, we ask you to provide our office with a driver's license or other picture identification. Annually, or as changes occur, we will ask you to update and sign our Family Information Form. We will scan your insurance card, ID, and Family Information Form, into your child's electronic medical chart. We will check these documents prior to releasing your child's records. We will take a picture of your child for your child's electronic chart. This photo helps us identify your child during our routine operations. Your child's photo will not be released without your permission.
  10. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.

# ADVANCED BENEFICIARY NOTICE

We have developed a list of services that may **NOT** be covered by your insurance carrier. The purpose of this list is to help you make an informed choice about whether or not you choose for your child to receive certain services. The fact that your insurance carrier does not cover a service does not mean that you should not receive that service, it just means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance carrier, you will be financially responsible for the balance on your account.

## **SERVICE**

## **CPT Code**

OAE-Evoked Auditory Test (hearing test)	92587
VEP-Visual Evoked Potential Test (vision test)	95930
Developmental Testing	96110
Preventive Medicine Risk Management <i>(counseling for delayed vaccine schedule)</i>	99401/99402
30 Month Checkup <i>(This is recommended by the AAP but may Not be covered by all insurance plans)</i>	99392 established patient 99382 new patient
*Well Checkups over the age of 18 years	99395 established patient 99385 new patient
Human Papilloma Virus Vaccine (HPV)	90649 (male and female)

**\*When being seen for a well check over the age of 18 years, please call your insurance carrier and verify that they will pay for services provided by a pediatrician.**

**If a provider performs a service not listed above, it will still be the financial responsibility of the parent/guardian if denied by your insurance carrier.**

**Signature of Understanding:** I have read and understand the above stated financial policy.

\_\_\_\_\_  
Childs Name

\_\_\_\_\_  
Childs Date of Birth

\_\_\_\_\_  
Patient or Parent/Guardian if Patient is under 18 years of age

\_\_\_\_\_  
Date

## **ASSIGNMENT OF BENEFITS**

I, the undersigned authorize payment of medical benefits to Roswell Pediatric Center, P.C., for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

\_\_\_\_\_  
Patient or Parent/Guardian if Patient is under 18 years of age

\_\_\_\_\_  
Date

## **Late Arrival/No Show Policy**

Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule to another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. If you "no show" three times we reserve the right to discharge your child from the practice.

**Missed or cancelled Appointment Policy:** Check-up, Consultation, and Nutritionist appointments that are missed or not cancelled within 24 hours of the scheduled appointment time, will be charged a missed appointment fee of \$75.00.