

## **Financial Policy for Carolina Pediatrics of The Triad, P.A.**

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

- ü Always bring your current health insurance card to the office.
- ü Please notify us at time of check-in of any changes in insurance, address, phone #, etc.
- ü Please pay your co-pay or deductible at the time of service; or if you do not have insurance, please come prepared to pay for your visit in full.
- ü Please check with your plan as to the participation status of the physician you are seeing. We will not deny care to any patient due to uncertainty of participation status of our physician with your insurance plan, understand you are responsible for verifying this information with your carrier. There may be services provided that your Insurance carrier does not cover, you will want to verify and understand your benefits. You agree to pay any portion not covered by your insurance.

**Monthly Statement:** If you have a balance on your account, we will send you a monthly 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 by the end of the month.

**Past Due Accounts:** If your account becomes past due, we will take the necessary steps to collect this debt including referral to a collection agency. If there becomes a need to send the balance of an account to collection due to non-payment of the account, the physicians of Carolina Pediatrics, P.A. may no longer be able to provide care. In this case, the guarantor will be notified of this by certified mail and given 30 days to find a new medical provider. A processing fee will be applied to past due accounts.

All accounts sent to the collection agency will be reported to the Credit Bureau.

**Payment Options if you have Insurance:** We are required by our insurance contracts to collect all co-pays at the time of service.

**Payment Options if you have NO Insurance:** Your choice is to pay by cash, check or credit card on the day that treatment is given. If payment is made in full at the time of service, Carolina Pediatrics will reduce the cost of service by 20%. If payment cannot be made in full at the time of service, a budget agreement can be made to have services paid within 90 days with the 1<sup>st</sup> payment payable the day the service is rendered. If payment in full can not be made, a processing fee will be applied to your account.

**Medicaid:** It is the patient/guarantor responsibility to present a current Medicaid card. You are responsible for payment if the card is not presented.

**Divorce:** In case of divorce or separation, the parent authorizing treatment for the 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 from the other parent.

**Insurance Release:** This is to certify that you have been informed prior to receiving treatment today that your health plan may not be liable for service rendered if any of the following conditions apply:

- ◆ You may have a pre-existing condition or other diagnosis that may not be covered by your plan.
- ◆ Provider not participating in your health plan.
- ◆ Unmet deductible under your health plan contract.
- ◆ Services may not be covered under your health plan.
- ◆ Well child check-up, immunizations, as well as other routine services may not be covered by some insurance plans. Please check with your insurance carrier if you are not sure if routine services are covered. Please check with your insurance carrier if you are not sure of your plan benefits.

**Returned Checks:** There is a fee (currently \$25.00) for any checks returned by the bank.

**Missed Appointment Fee:** You will receive a letter outlining our **No Show policy** and fee due: Missed **Well Checks** 1<sup>st</sup> \$20, 2<sup>nd</sup> \$50, and 3<sup>rd</sup> \$50 and possible dismissal. **Sick Visits** 1<sup>st</sup> \$10, 2<sup>nd</sup> \$25, and 3<sup>rd</sup> \$25 with possible dismissal.

**Copy of Medical Records:** You will need to complete the authorization to release records form, which can be obtained from our office. This form needs to be completed in its entirety in order for us to process the request. All account balances should be paid before records are transferred. There is a \$20.00 fee for records for the first child or a \$30.00 fee for a family. We require a 48-hour notice to prepare your records for transfer.

**Forms:** There is a \$5.00 fee for school, sports or daycare forms. There is a \$10.00 fee for FMLA forms.

We require 48 business hours to prepare your forms.

**ADD/ADHD Prescription Refills:** Please allow 48 hours when requesting a refill for these medications before picking up.

**Effective Dates:** Once you have signed this agreement, you agree to all of the terms and conditions contained herein, and the agreement will be in full force and effect.

This is an agreement between Carolina Pediatrics, P.A., as creditor, the Patient/Guardian, or Parent as debtor, named on this form.

In this agreement, the words "you", "your", and "yours" mean the patient/debtor. The word "account" means the account that has been established to your name to which charges are made and payments credited. The words "we", "us", and "our" refer to Carolina Pediatrics, P.A.

By executing this agreement, you are agreeing to pay for all services that are received.

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Knowing this, I request that services be performed and I agree to be responsible for any charges incurred. I understand that if I fail to make payment when due and my account becomes delinquent or is turned over to a collection agency or attorneys for collections, the undersigned shall pay all collection agency fees, court costs and attorney fees, and risks being dismissed from the physician care of Carolina Pediatrics, P.A.

I have read this Financial Policy as outlined above and on the reverse side of this page, and understand that I am ultimately responsible for the charges incurred by my child/children as their legal parent or guardian.

Patient Name: \_\_\_\_\_

Parent/Guarantor Signature: \_\_\_\_\_

Date:\_\_\_\_\_

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