Financial Policy

Thank you for choosing ESD Pediatric Group (ESD) as your pediatric primary care provider. We are committed to providing you with the highest quality care at a fair and reasonable cost. In order to accomplish this goal, we are requesting your help in avoiding unnecessary billing issues that may happen as a result of incorrect insurance information.

The following is a summary of our payment policy. **Acknowledgement and understanding of this Financial Policy must be signed.** Patients cannot see our provider unless this statement is signed.

PAYMENT IN FULL IS DUE AND EXPECTED AT TIME OF SERVICE

*****Please read and initial the following five sections. *****

_______ **Payment is required at the time services are rendered:** This includes applicable coinsurance, co-payments and payments for services not covered or denied by the insurance company. If you participate in a High Deductible Insurance plan, we require a minimum of $50 payment at the time of service. If your insurance company has the ability to adjudicate claims at the time of service, 100% of the adjudicated balance is expected at the time of service. Currently, Humana and United Healthcare have this capability.

_______ **Self-pay accounts:** If you do not have insurance, please come prepared to pay for your visit in full. ESD offers a 20% discount for all self pay services paid in full on the day of the visit. If payment cannot be made in full at time of service, a budget agreement can be made to have the service paid within 90 days with the first payment payable the day the service is rendered.

_______ **Missed Co-payments:** We are required by our insurance contracts to collect all co-payments at the time of service. Failure to collect co-payments puts the responsible party and ESD in default of the insurance contract. Any co-payments that are not paid at the time of the office visit will be charged a **"Missed Co-pay processing Fee"** of $25.

_______ **Returned Check Fee:** There is currently a $30 fee for any checks returned by the bank. Cash or credit card payments will be required for any account with more than one Returned Check Fee in a twelve month period.

_______ **Missed Appointment Fee:** Broken appointments represent a cost to us, you and to other patients who could have been seen in the time set aside for you. Cancellations are required 24 hours prior to the appointment. Appointments not cancelled 24 hours in advance will result in a "No Show" fee of $30 and may result in dismissal from the practice. This fee must be paid before a new appointment is scheduled. Patients with *two* missed appointments in a twelve month period will be asked to transfer their records to another practice.

ESD Pediatric Group accepts cash, personal checks, debit cards, Visa, Master Card, Discover and American Express.

BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

The Financial Policy continues on the next page.

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

By my signature below, I authorize the release of information necessary to file a claim(s) with my insurance company (ies) and assign benefits otherwise payable to me, to the provider, or the group indicated on the claim. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account. I understand that co-payments, deductibles and payments for services not covered or denied by the insurance company are due at the time of service. I understand that if my account goes to collections, I shall pay all collection fees and costs incurred by ESD. I certify that this information is true and accurate to the best of my knowledge and will notify the office of any changes to my information, such as, but not limited to change in address, telephone numbers, insurance coverage, custodial relationships, etc. I have read, understand, and agree to abide by the Financial Policy.

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

Patient's Name(s):____

Guarantor Name: ____

Parent/Guardian Signature: _______________________________________ Date: ________________________

INSURANCE FILING AND ASSIGNMENT OF BENEFITS

Regarding Insurance: As a courtesy to our patients, ESD will file claims to any insurance carrier with whom we are participating providers. It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance. If the insurance company has not processed and paid the claim within a timely manner or has denied the claim, payment of the account in full becomes the responsibility of the person bringing the child to our office for treatment.

Change of Insurance/Change of Address: Please notify the office as soon as possible of all insurance and address changes. The guarantor is responsible for all charges not paid as a result of change of insurance coverage.

Payments: Unless other arrangements are approved by us in writing, the balance of your statement is due and payable when the statement is issued. Payment is due within thirty (30) days from the statement date. If you feel that your claim was unfairly denied by your insurance company, it is the parent/guardian's responsibility to pursue the insurance company on their child's behalf.

Divorce: In the case of divorce or separation, the parent authorizing treatment for a 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 I have been informed prior to receiving treatment today that my health plan may not be liable for service rendered if any of the following conditions apply:

- My child/children may have a pre-existing condition or other diagnosis that may not be covered by my plan.
- Provider not participating in my health plan.
- Unmet deductible under my health plan contract.
- Services may not be covered under my 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.

Outstanding Balance: If you have a balance on your account, you will receive 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. If your account becomes past due, we will take the necessary steps to collect this debt.

ESD understands that full payment may not be possible in certain circumstances. As a courtesy, ESD offers a payment plan. This payment plan is a binding contract referred to as a "Budget Agreement". In order for services to be rendered, patients with budget agreements must be in full compliance with all conditions of the budget agreement. Failure to make scheduled payments on the budget agreement or not paying off a balance in full may result in your account being turned over to a collection agency and dismissal from the practice.

If we have to refer your account to a collection agency, you agree to pay all collection costs that are incurred. All accounts sent to the collection agency will be reported to the Credit Bureau. If there becomes a need to send the balance of an account to a collection agency due to non-payment of the account, the physicians of ESD Pediatric Group will no longer provide care. In this case, the guarantor will receive written notification and given adequate time to find a new medical provider.

If your account is sent to collections and then paid in full, the parent /guardian may request the practice to reinstate the patient's account. If the practice permits reinstatement, the practice will charge a $25 reinstatement fee which is not billable to insurance. This fee must be paid prior to scheduling any future appointments.

Waiver of Confidentiality: You understand if the account is submitted to a collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Transfer of Records: Should you wish to transfer care to another physician, 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 balances should be paid before records are transferred.

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

Billing Inquiries: Questions about a bill should be directed to our Billing Manager at 513-248-3063.

Revised: December 1, 2010