Financial & Office Policy – Effective 7-25-2017

Dear Families,

In the interest of good healthcare practice, it is desirable to establish a financial policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that goal. Insurance reimbursement is a contract between you, your employer, and the insurance carrier. **YOU** are responsible for payment of your account. **YOU** are responsible to be aware of your benefits and to contact your carrier directly when issues arise regarding timely payment of claims or denials. Insurance(s) are gladly billed as a courtesy to our patients when current card(s) are provided to us. We cannot accept responsibility for follow-up on your claims or for negotiating a disputed claim, but our staff will assist you if needed.

The following policies must be agreed upon:

1. **All co-pays** are due at the time of service. A $25 charge will be added to your account if not paid within 24 hours. Non-urgent care may be subject to rescheduling when co-pay is not paid. Please do not ask us to waive co-payments; it is considered a breach of the insurance contract and it can lead to denial of payment by the insurance company.

2. **We run a Zero Balance office**. All outstanding accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with us. All personal accounts past due more than 60 days from the date of billing will accrue a $10 monthly late fee. Accounts may be assigned to an outside collection agency and reported to the credit bureaus if the personal balance is over 120 days old. A $50 collection fee will be assigned to your account if sent to an outside collection agency.

3. **Insurance Payment**: If insurance payment is not received within 60 days of submission of the claim, you will be informed of your responsibility to contact the insurance company and ensure that payment in full is received promptly. It is your responsibility not ours that your insurance company pays on time.

4. **Form completion for charge:** The minimum charge for review or completion of a non-WIC or Medicaid form is $5 per form. Charges vary with duration of physician involvement and time. The physician completing the form determines the charge. Sports physical/Camp/daycare forms are $10. College forms $15. Family Medical Leave Act forms are $10. The minimum charge for standing orders such as “Food Allergy Action Plans”, “Asthma Plans”,“Medication Dosage Forms” is $5.

5. **Returned check**: A $15 charge will be added to accounts for each check that is not honored by your bank. This is in addition to any fees that the bank charges us for your returned check. If two checks are bounced, we will not accept checks for payment on your account.

6. **Patient Satisfaction**: Our policy is to make your experience an exceptional one. When we succeed, we would appreciate you telling your family and friends about our offices.

7. **Misunderstandings**: It is our company policy to ensure the complete satisfaction of all our patients with the services and care that they receive at our offices. However, it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to promptly address and resolve the matter, provided it is brought to our attention in a timely, appropriate, cordial manner. You can expect that our staff will treat you with courtesy, professionalism, and respect, and will strive to achieve mutual understanding.

Acknowledgement of Receipt of PedEmerge Financial & Office Policy 7-25-2017

I have read and understand my financial obligations. I understand that I am personally responsible for this account regardless of medical insurance, divorce decree or otherwise. I understand that in the event this account becomes delinquent, by affixing my signature hereto, I am bound and responsible for all charges upon this account. I further understand that delinquent accounts may be assigned to a collection agency and further reported to a credit bureau. In the unfortunate event that collection is necessary, the undersigned expressly agrees to pay all prevailing party attorney fees and costs. I authorize Ivy Pediatrics to call me on my home/cell/work numbers for collection purposes.

Signature ____________________________________ Date ________________

Print Name/Relationship to child(ren) ____

Print patient(s) name(s) ____