PREMIERE CHILDRENS PHYSICIANS P.A.

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PRACTICE AND FINANCIAL POLICY

Welcome and thank you for choosing Premiere Childrens Physicians P.A. as your healthcare provider. We are committed to providing you with quality and affordable healthcare. To answer some of the questions you may have regarding patient and insurance responsibility for services rendered, we have provided this financial policy. Please read over carefully, sign and date in the space provided. We will address whatever questions you may have before signing, and a copy will be provided to you upon request.

1. **INSURANCE:** We participate in various types of insurance plans including Medicaid. Please present your current insurance card to the receptionist for verification along with your drivers license for proof of address. If you are without medical insurance, payment in full is expected at each visit unless prior arrangements have been made with our billing department. Our practice accepts, cash, checks, money orders, Visa and Mastercard.

2. **PATIENT RESPONSIBILITY**: It is ultimately your responsibility as the patient to know your insurance benefits. Failure in knowing your insurance coverages may result in unforeseen charges for you . Be sure to contact your insurance company with any questions regarding exactly what is covered. **UPON YOUR VISIT, IF YOU ARE AWARE THAT SOMETHING IS NOT COVERED BY YOUR PLAN, YOU MUST INFORM US, SO THAT THE CORRECT PAYMENT ARRANGEMENT CAN BE MADE.**

3. **CO-PAYMENTS** : **ALL CO-PAYMENTS ARE DUE AT THE TIME OF SERVICE**. This arrangement is a contractual obligation between you and your insurance company. We must collect all co-pays. Failure to collect co-payment from our patients can be considered fraud. Please help us in upholding the law by paying your co-pay in full at time of service.

4. NON- COVERED SERVICES: Please be aware that some and perhaps all of the services rendered may not be covered by your insurance or may not be considered reasonable or necessary by Medicaid or other insurers. It is your obligation to pay in full at the time of service. **IF THESE CLAIMS ARE SUBMITTED TO THE INSURANCE COMPANY AND ARE DENIED, IT IS YOUR RESPONSIBILITY TO PAY IN FULL WHATEVER CHARGES WERE SUBMITTED TO THE INSURANCE COMPANY. WE CANNOT BY LAW MAKE ADJUSTMENTS TO THE CLAIM AFTER THE FACT, SINCE YOU SHOULD HAVE KNOWN THE LIMITATIONS OF YOUR PLAN IN ADVANCE.**

5. PROOF OF INSURANCE: All patients must complete our patient information form before seeing the physician. We request a copy of you driver's license or other form of ID, and current valid insurance information to provide proof of address and insurance. . Your current insurance card must be presented to us at each visit.

6. **CLAIM SUBMISSION:** We submit claims to your insurance as a courtesy to you and will assist in any way reasonable to get your claims paid . Your insurance company may need you to supply certain information directly. It is your responsibility to comply. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

7, COVERAGE CHANGES; If there is a change in insurance coverage, please notify us before or upon you next visit so that the appropriate changes can be made to our records.

8, NON-PAYMENT: If your account is over 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated with our billing office. If the account remains unpaid, we may refer your account to a collection agency or collection bureau and you and your immediate family may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail, that you have 30 days to find alternative medical care. During the 30 day period our physician will only be able to serve you on an emergency basis, with payment due at time of service with cash or credit card.

9. NO INSURANCE: If you do not have insurance and is unable to pay for services in full, you will then be referred to our billing services. Please note that our billing service may need other documents to determine, if you are eligible to allow for an adjustment in your bill or payment plan.

10. MISSED APPOINTMENTS /LATE CANCELLATION: Broken or missed appointments represent a cost to us, and to other patients who could have been seen in the time set aside for

you. Cancellations should be requested 24 hours prior to the appointment date. Excessive abuse of scheduled appointments may result in discharge from the practice.

11. RETURNED CHECKS FOR NON SUFFICIENT FUNDS: Any patient having a check returned to Premiere Childrens Physicians for **insufficient or non – sufficient funds will be charged** a **$25.00 fee. This** is in addition to any fees charged to you by your financial institution. Cash, money order or credit card will be the only form of acceptable payment for a returned check. Payment will be expected within 10 days of being notified, otherwise these accounts will be turned over to a collection agency / bureau for collection.

12. SCHOOL NOTES: School notes are issued by our office if your child has been absent from school due to illness. The child must be seen by our office within 48 hours. prior to his/her return to school. It is unlawful to issue school notes for children who were not seen by our office. We try our best to schedule sick patients within the 48 hour time frame.

13: TRANSFER OF PATIENT RECORDS: if you wish to transfer your child's records to another physician or healthcare practice, please note that a **copying fee that is set by the State of Maryland will be charged**. These fees must be paid prior to releasing of the records. You may receive more details and a fee sheet from our receptionist if you so desire.

Our practice is committed to providing excellent treatment for our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for reading and understanding our Practice and Financial policy. Please let us know if you have any questions or concerns.

I have read, and understand the Practice and Financial Policy of Premiere Childrens Physicians P.A. and agree to abide by its guidelines.

____________________________________ ____________________

Signature of Patient or Responsible Party **Date**