Financial Agreement

Patient's Name : _____

Our office seeks to provide cost efficient medical care for all of our patients. To help us achieve this goal you, as the patient, or guardian, agree to the following for the duration of your doctor-patient relationship with us.

Frequently, we coordinate your care with other Health Care Providers (ex: hospitals, specialists, labs, imaging centers etc.) We agree to provide your medical records to those providers, according to HIPAA regulations, when the records are needed to provide healthcare services to you. You also authorize us to provide your medical records to others authorized by us or a third party payer to conduct quality assurance and/or utilization review.

Please realize that your insurance contract is between you and your insurance company. You are financially responsible for services rendered. However, as a courtesy, we will bill your insurance company, if it is one we are contracted with. In these cases you agree to assign all payments to our office and authorize the collection of such insurance benefits by our office. Any co-payments are due at the time of service unless other arrangements are made in advance. You agree to pay any amounts not paid by your insurance company. If we are not contracted with your insurance company, payment must be made at the time of service and you are responsible for filing your claim. **If there are any changes to your insurance it is <u>your</u> responsibility to notify our office immediately. You will be responsible for paying the entire amount if we have incorrect insurance information. We will not file an appeal on your behalf.**

If you default on your account and your account is assigned to an outside collection agency, you will be charged a $10.00 collection fee. If your account is litigated you will be responsible for reasonable attorney fees, court costs and interests set forth by the court. If your account is turned over to a collection agency you may be dismissed as patients regardless of the type of insurance you have. Any checks returned for non-payment are subject to fees set forth by state and local laws.

_____ _____

Responsible Party's Signature Date

Office Policies

(Initial next to each policy)

_____ *<u>Current Insurance</u>*

It is your responsibility to provide our office with your current insurance card at every visit. **It's recommended that you call your insurance to make sure our office is in network for your policy**. Failure to provide us with this important information may result in the denial of your claim. We will not file an appeal on your behalf with your insurance company. You will be responsible for paying the entire amount.

_____ *<u>Outside Services</u>*

Any services rendered outside of our office (ex: laboratory tests, x-rays etc.) are billed separately by outside facilities. We do our best to send patients to in-network facilities. It is your responsibility to know your insurance policy. There may be an in-network facility your insurance company requires you to go to. Clown Pediatrics, P.C. is not responsible for any out-of-pocket expenses you may accrue from using an out-of-network facility.

_____ *<u>Custody</u>*

It is the parent's responsibility to provide updated legal documentation to our office regarding custody agreements for your child, who we can share medical information with, and who has decision making authority. If we do not have updated documentation on file, we will assume both parents are able to have access to medical records.

(Initial next to each policy)

_____ *Divorce Decree*

Clown Pediatrics, P.C. will not forward bills to other parties regardless of court rulings or divorce decrees. The adult that brings in the child is responsible for copays and deductibles.

_____ *Newborn Coverage*

It is very important to **add your child to your insurance policy within the first 30 days**. If you fail to add your baby in a timely manner and there is a gap or lapse in coverage you will be responsible for cash payment for any service rendered.

_____ *Well Child/Routine Exams/Immunization Coverage*

We do not verify benefit coverage with your insurance company. It is your responsibility to verify if your insurance plan covers routine well child exams including immunizations. This type of visit can cost up to $900. Please contact our business office if you have determined your insurance will not cover our services. We are happy to make arrangements with you. Unfortunately, we are unable to discount our services after the visit has occurred.

_____ *Medication Refills*

We require 24 business hours notice for all prescription refills. Refills should be requested during business hours Monday-Friday. Refills will not be called in over the weekend.

_____ *Forms*

We are happy to complete forms, such as daycare and school physical forms. They will be completed at no-charge if you are here for a visit or allow us **72 hours to complete**. All forms requiring less than 72 hours will result in a $5.00 fee per form. A standard medical record copying fee will be assessed should we send your child's medical chart to another physician.

_____ *Medical Records*

A medical records fee of $10.00 will be charged in advance for all medical records regardless of the reason they are requested. All medical records will be placed on a disc (or USB drive by request). A $10.00 rush fee will be added if records are required within two business days. This fee includes postage.

_____ *Referral/Prior Authorization*

It is your responsibility to know if your insurance company requires a prior authorization or written referral for a specialty service. You must notify our office before the appointment occurs. Our office will not be held responsible for services denied for lack of authorization.

_____ *No-Show Policy*

We require **24 hours' notice if you need to cancel your Well Child Visit**. This allows us to offer this appointment time to another patient. We require **1 hour notice if you need to cancel your sick visit**. Failure to notify our office will result in a no-show and you will be billed a $10.00 no-show fee. This fee is not billable to your insurance company. If a family accumulates 7 no-shows in a 2 year period, we reserve the right to dismiss the entire family from our practice.

_____ *Evening and Saturday Visit Charge*

Appointments that occur Monday through Friday from 6 p.m. - 7 p.m. or on Saturdays from 9 a.m. - 12 p.m. will incur an additional $20.00 convenience charge. This includes well-check visits. Insurance may or may not pay for this. If they do not pay, this charge will be your responsibility.

_____ _____

Signature Date

_____

Relationship to Patient (Parent/Guardian/Self if 18+)