Office & Financial Policy

Pediatric Associates is committed to providing your child with the best possible medical care, and a clear understanding of our financial policy is important to our relationship. Our physicians are contracted with most insurance plans; however, we recommend you verify our participation with your plan. Your insurance policy is a contract between you and your insurance carrier. Thus, it is your responsibility to understand and know the provisions of payment for services rendered at Pediatric Associates.

Pediatric Associates follows all billing rules as established by the National Association of Insurance Commissioners, State and Federal Guidelines.

The First 30 Days of Life

Most insurance companies provide automatic coverage for some, or all the first 30 days of life; *even* though the parent may choose not to enroll the baby for continuing coverage. It is mandatory parents provide their information, regardless of whether they plan to enroll the baby of coverage. We allow 30 days for you to enroll your newborn to your insurance plan(s). If at 30 days we are unable to verify coverage through the insurances you provide, the balance becomes your responsibility to pay in full prior to your babies 2-month appointment.

The Birthday Rule

The birthday rule applies to children covered under both of their parent's health insurance plans. An industry standard, almost all health insurers follow the birthday rule to determine which insurance is primary. The rule says that the parent with the earliest birthday month and day provides the primary insurance coverage. If both are in the same month, then coverage derives from the plan carried by the parent born earlier in the month. If both are on the same month and day, coverage comes from the parent who has been covered for a longer period.

Court documents, such as in a divorce can supersede the Birthday Rule, however those documents must be provided to Pediatric Associates and your insurance company; a copy will be kept in the patient(s) file.

Coordination of Benefits

It is the responsibility of the parents to notify their insurances of other existing or termed policies. Not updating the Coordination of Benefits with your insurance companies could result in the delay of payment or non-payment, leaving the responsibility of payment to the parents.

Proof of Insurance

___A copy of your insurance card is required at every visit. Without current insurance information your appointment will be cancelled and/or you will be financially responsible for the entire visit at the time services are rendered. You are required to sign a waiver stating you will be responsible for payment and the billing of your insurance.

___It is your responsibility to keep us updated with correct insurance information. If you provide incorrect insurance information, you will be responsible for a $25.00 reprocessing fee.

___Co-payments are due at the time of service. A $25.00 service fee will be charged if not paid by end of day.

___Secondary Insurance is billed as a courtesy *ONLY,* balances greater than 30 days are your responsibility and due in full immediately.

Patients 18 and Older

___Patients 18 years of age and above will be made financially responsible for services rendered at Pediatric Associates, even though a parent may carry insurance coverage. Laws (PHI) prohibit us from discussing medical and billing information with the parent, unless the patient gives written permission by completing the required forms.

Cancellation/No Show Fee

___We require 24 hours' notice to reschedule or cancel any appointment. Failure to provide at least 24 hours' notice will result in a $35.00 no-show fee. Three or more no show appointments within a family may result in the dismissal from the practice.

Non-Sufficient Funds

___A charge of $35.00 will be added to your account if your check is returned for non-sufficient funds. The balance in due in full within 10 days of returned check.

Divorced or Separated Parents

___The physicians focus is the care and well-being of your child(ren). We will not mediate between personal issues or financial disputes. A copy of court rulings specific to payment of medical bills will need to be kept on file.

Balance Due and Collections

___Statements are sent within 10 days of receiving an insurance payment/denial. Payment is expected upon receipt of said statement. Balances exceeding 90 days from date of service will be turned over to a

collection agency. An additional fee of $75.00 will be added to the account balance. In the event your account is assigned to a collection agency, your family will be dismissed from the practice.

Zero Tolerance Policy

___Pediatric Associates has a zero-tolerance policy when it comes to patients causing disruptive behavior. We do not tolerate abusive language, mistreatment of staff, profanity, threats of social media retaliation, and/or any threats of violence of any kind at Pediatric Associates. If a patient exhibits any type of inappropriate behavior, they will be asked to leave immediately and will be dismissed from our practice.

Pediatric Associates reserves the right to discontinue any services with patients who behave as aforementioned.

Please understand that, if you do have a concern or a problem regarding our office, we want to hear about it; but in a safe, constructive manner. We welcome suggestions for us to provide the best care possible, while also providing a safe environment for our patients and staff.

___I have read and understand the policies of Pediatric Associates.

I authorize the release of any medical information necessary to process any claim. I permit a copy of the authorization to be used in place of the original. Either I or my insurance company may revoke this authorization at any time in writing.

I authorize the doctor to release any medical information including diagnosis, x-rays, test results, reports and records pertaining to any treatment or examination rendered to my child. I understand that this medical information will only be used for the following purpose: diagnostic, referring physician(s) or insurance.

Patient Name_____

Responsible Party Signature_____Date_____

Relationship to Patient_____