Financial Policy of ABC Pediatrics, Ltd.

Our professional staff is committed to providing you with quality pediatric care and our business office is committed to assisting you with the financial obligations of your medical care.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. Therefore, we have outlined our financial policy so that patients will better understand the billing process and their responsibility in it.

ABC Pediatrics, Ltd. will:

1. File primary insurance claims on your behalf in a timely manner.
2. Seek information to process claims and answer any questions about claims.
3. Issue statements to you once insurance has made payment for services.
4. Accept payment by cash, check, and most major credit cards.
5. Arrange payment plans when necessary through the office manager.
6. Help resolve billing problems diligently for 60 days.

Your responsibilities will be to:

1. Complete our patient information form and supply any insurance information that is necessary to process your claims including benefits information.
2. Notify us of any changes in your insurance status or insurance company.
3. Pay your co-pay at the time of service. If you cannot pay your co-pay at the time of service a $20.00 fee may be charged to you.
4. Pay any outstanding balance which is unpaid, denied or delayed by your insurance carrier beyond 60 days after the date of service.
5. Call your insurance carrier, at our request, to expedite payment for delayed claims before our 60 day limit has been reached.
6. Call your insurance carrier when a submitted claim was denied. Denied and disputed claims do not suspend your requirement to pay for services rendered.
7. Be responsible for deductibles or uncovered expenses. This may include charges for screening forms that are required by law or recommended by the American Academy of Pediatrics. Patients seen for a well visit may incur additional charges for any significant services, such as counseling for immunizations, risk factor reduction intervention, or any illness, condition or procedure. Patients seen in the office during regularly scheduled evening, weekend or holiday office hours will incur an additional charge.
8. Forward any payment which received by you from the insurance company that is owed to ABC Pediatrics, Ltd.
9. Pay a $25.00 fee per check returned to us by the bank for non-sufficient funds (NSF).
10. File claims with your secondary insurance carrier. Any balance due after primary insurance has processed is due immediately. NOTE: We do not file Medicaid as secondary insurance.
11. Authorize ABC Pediatrics, Ltd. to provide your insurance carrier with any clinical or financial information that they may require.
12. Pay in full for office visit at the time of service if no current insurance card is presented.
13. Inform us of any appointments you need to reschedule or cancel. You may be charged a $50.00 fee for sick appointments not cancelled within an hour and well visits within 24 hours. You will be charged $50.00 for a “no show appointment.
14. We will do our best to resolve insurance issues and will enlist your help when necessary before asking that you pay any balance that is 60 days past due. Your insurance is a contract between you and your insurance carrier. Therefore you will be more likely to get the carrier to meet their financial obligation when they delay payment on your claims. Please remember that we file insurance as a courtesy to you. You, not the insurance carrier, are ultimately responsible for any unpaid fees.

I certify I have read, understand and agree to adhere to ABC Pediatrics, Ltd. Financial Policy.

_____ _____

Responsible party’s signature Date Patient’s name printed

Patient Name _____

_____

_____

For Office use:
Acct# _____
Date _____
Initials _____

The following information is needed to provide service and process claims with your insurance provider. Please contact your insurance carrier using the toll free number on the back of your insurance card and ask the following questions.

Our provider tax ID# is 36-4122365. Give the insurance company our tax ID # and ask if we are in their network.

1. Name of insurance company? _____
2. What type of plan is this? PPO, POS, EPO or other
3. Name of network? _____
4. Effective date of policy _____

If In-Network ask:

Deductible amount
Individual $_____
Family $_____
Date deductible starts over _____
What services are subject to ded? (Circle)
Hospital, office visits, immunizations, labs,
Wart treatments, strep tests

Lab preferred provider? _____
Medical/sick visit copay $_____
Well baby/child care copay $_____
Are immunizations covered? Yes / No
At what percentage? _____%
Any limits on immunization? Yes / No
If yes, dollar amt limit is $_____per ___
Are there any limits on well care? Yes / No
If yes, dollar amt. limit is $____ per ____
Number of visits limit is _____ per _____
Age limit? _____

If Out-Of-Network ask:

Deductible Amount
Individual $_____
Family $_____
Date deductible starts over _____
What services are subject to ded? (Circle)
Hospital, office visits, immunizations, labs,
Wart treatments, strep tests

Lab preferred provider? _____
Medical/sick visit copay $_____
Well baby/child care copay $_____
Are immunizations covered? Yes / No
At what percentage? _____%
Any limits on immunizations? Yes / No
If yes, dollar amt limit is $____ per ____
Are there any limits on well care? Yes / No
If yes, dollar amt limit is $_____ per ____
Number of visits limit is _____per _____
Age limit? _____

Please call our office with this information as soon as possible and return this completed form to our office at your first visit.

We hope this provides you with a basic understanding of our financial policy. Our staff is trained to help you with any insurance questions you may have. Only your employer can address how your plan is administered. If you have any questions regarding our payment structure, please feel free to contact our business office.