Ellicott City Pediatric Associates, P.A.

FINANCIAL & OFFICE POLICY

Thank you for choosing Ellicott City Pediatric Associates, P.A. as your pediatric provider. It is our hope that our patients understand our credit, collections and office policies are a necessary part of assuring the financial resources required to maintain vital health care service for our patients. Our goal is to provide and maintain a good provider-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have questions, please ask a member of our staff.

Appointments:

- We value the time we have set aside to see and treat your child. If you are not able to keep an appointment, we would appreciate no less than 2 hours cancellation notice. Please remember that all of our appointments are scheduled appointments and if notice is not received, a **$25.00** no-show and late cancellation fee may apply. If there are 3 no shows within one year you may be asked to transfer care to another practice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, on certain days it may not be possible and it may be necessary to reschedule your appointment.

Initial:_____

Permission for Medical Care:

- All children under the age of 18 must be accompanied by an adult. Any adult who is not the patient's legal guardian must have written permission to authorize medical treatment for the child.
- Patients who are age 18 or older will be given the option to sign a release allowing our office to discuss their care (including diagnoses and lab work) with their parents or guardians. By law, we are not permitted to disclose medical information pertaining to any patient aged 18 or above to their parents unless the patient has given us written permission to do so.
- Parents of adolescents should be aware that Maryland State law permits adolescents to obtain certain confidential services without notifying the parents.

Initial:_____

Referrals:

- Advance notice is needed for all non-emergent referrals, typically 3-5 business days.
- Retroactive referrals cannot be written.
- Generally, we will not agree to a referral for a problem we have not been consulted about first.
- It is your responsibility to know if a selected specialist or lab participates with your insurance.

Initial: _____

Forms:

- We require 3-5 business days to complete your forms, please plan accordingly.
- The child must have an up-to-date (within the past 12 months) physical exam on file with our office.
- $10.00 form completion fee is due at time of pick-up.

Initial:_____

Insurance Plans:

- It is your responsibility to keep us updated with your correct insurance information. At each visit you will be asked to present your insurance card to ensure our office has the most up-to-date card on file.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
- As we are your primary care provider (PCP), make sure our physician or practice name appears on your most up to date card. If your insurance has not been informed that we are your child's PCP and we cannot confirm that we are, you must pay for the visit or reschedule.
- It is your responsibility to understand your benefit plan.
- Not all plans cover well child visits, vision and hearing exams/screenings, or other services provided by us that are recommended by the American Academy of Pediatrics and are the standard of care. If these services are not covered, you will be responsible for payment.
- If your insurance plan allows a certain number of visits per year and those visits have been maxed, you will be responsible for payment.

Initial:_____

Financial Responsibility:

- We do not get involved with domestic disputes and custody issues. Our policy is to obtain the co- payment at the time of service from the parent/guardian bringing the child to the appointment. Any balance left from the insurance company will be billed to the guarantor on the account. If bills are ignored, we will hold the accompanying parent responsible for full payment. It will then be that parent's responsibility to seek repayment from the other party.
- According to your insurance plan you are responsible for any and all co-pays, deductibles and co-insurances.
- Co-pays are due at the time of service.
- Patient balances are billed monthly; we ask that you pay your balance upon receipt of the statement.
- If previous arrangements have not been made with our billing office, any account balances 60 days past due will have a $15.00 late fee applied to the account. Balances reaching 90 days overdue will have a block placed on the account in which no well-child visits can be scheduled until payment is received. Balances reaching 120 days past due will be forwarded to a collection agency. If your account is sent to a collection agency you will be asked to transfer your care to another practice.
- A sick patient present in our office will not be denied care due to financial difficulties.
- A $25.00 fee will be charged for any checks returned by the bank. Repeatedly presenting checks that are returned will result in your account being placed on a "cash only" restriction.
- For your convenience the following forms of payment are accepted: Cash, Personal Check, Visa, Master Card and Discover.
- Ellicott City Pediatric Associates, P.A. reserves the right to change fees without notice.
- Any families asked to transfer care for non-compliance of our policies will not be accepted back into our practice.

Initial:_____

I have read and understand this office and financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined in this document.

Patient Name – please list all children that are patients of Ellicott City Pediatric Associates:

_____ DOB _____ _____ DOB _____

_____DOB _____ _____ DOB _____

_____DOB _____ _____ DOB _____

_____ DOB _____ _____ DOB _____

Responsible Party's Name (Print): _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____