Pediatric Associates of Cincinnati, Inc.
Financial Policy

We welcome and thank you for choosing Pediatric Associates of Cincinnati, Inc. for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.

Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Visa, MasterCard, and Discover. We also provide our patients the ability to pay for their accounts over the phone at 513-791-2532. The business office is open Monday through Friday 9am – 5pm.

In order to achieve our goal of providing you with the best care possible, we need your assistance and understanding of our financial policy:

Things to bring with you to EACH appointment:

- Health Insurance Cards
- Method of Payment

Appointments:

- Please arrive for your appointment 10 minutes early.
- If you are more than 10 minutes late for your appointment, you will be marked as a *No Show* and will need to reschedule your appointment. Repeated *"No Shows"* may result in a penalty charge equal to the amount of the office visit.
- It is your responsibility to verify that the physician is currently under contract with your insurance plan.
- Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Co-payment and Other fees:

- All co-pays are due at the time of service. *Any co-pay not received at the time of service will result in a $5 processing fee. If co-pay is received within 7 days of the date of service, the processing fee can be waived.*
- There will be a fee of $30 for any returned checks to our office.
- All balances are due prior to any further service provided by our office.

"In Network" vs. "Out Of Network" Insurance:

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- We are contracted with multiple insurers to accept assignment of benefits.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a *self pay* patient.
- We are required to file with your primary insurance carrier only. As a courtesy to you we will file charges with any secondary insurance carriers for reimbursement.

Payment in full is due at the time services are rendered:

- Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-out process. Failure to produce payment may result in your appointment being rescheduled.
- Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service.
- Any delinquent balance may incur a $5 monthly statement processing fee, in addition to the initial balance.
- As a courtesy to our patient, we gladly accept cash, check, money order, Visa, MasterCard, and Discover.
- Failure to pay balances my result in discharge from the practice.

Self Pay Patients:

- Patients with no insurance and no health insurance carrier to file a claim, will be offered a reasonable discount for cash payments. We will give you an estimate of what will be due at the time of service and that amount will be due at the time of service.

Please read other side

Additional Paperwork:

- Any paperwork needed to be filled out by the physician, ***without an appointment,*** will result in either a $5 or $10 charge, depending on the length of the paperwork. The fee will be waived for the first form and each subsequent form there after will be subject to the $5 or $10 fee per calendar year.
- A 48 hour notice is required for all paperwork.

Minor Patients:

- The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form on file if minor arrives unaccompanied for an appointment.
- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient's parent(s) or guardian(s), unless otherwise documented.
- Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient. Upon request a copy of this financial policy will be provided to each parent if living in separate residences.

Lab/Hospital Charges:

- Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation or Benefits (EOB) from your insurance carrier.

Collections and Outstanding Balances:

- The provider reserves the right to add a $5 monthly statement processing fee to any delinquent account over 60 days.
- Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney may be subject to a collection fee of 30%, which will be added to the total balance due at the time of write-off.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.

Payment Plans:

- Our office will be happy to work with you in order to pay any balance due our practice.
- Please contact our business office to work out a payment plan with our practice.
- Please mail all payments to our office: 4370 Malsbary Road, Suite 100, Cincinnati, Ohio 45242. Our business phone number is 513-791-2532.

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.

Pediatric Associates of Cincinnati, Inc.
4370 Malsbary Road, Suite 100
Cincinnati, Ohio 45242

Effective 01/01/2010

Patient Consent Form

By signing this document, I, _____, have fully read and understand the
Parent/ Guardian
financial policy of *Pediatric Associates of Cincinnati, Inc*. I hereby consent to allow *Pediatric Associates of Cincinnati, Inc*. to reach me via: (check all that apply)

_____Home phone: ( ) _____-_____

_____Cell phone: ( ) _____-_____

_____Work phone: ( ) _____-_____

I understand and consent to *Pediatric Associates of Cincinnati, Inc*. to use an automatic dialer to reach me. I will cooperate with the billing department of *Pediatric Associates of Cincinnati, Inc*. to ensure payment for my services. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial policy may be amended at any time without prior notification to me, the parent/guardian/patient. In the event that the patient is a minor, I am the parent and/or guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

Failure to sign this form may result in rescheduling your appointment.

_____
Print name of patient(s)

_____ _____
Signature of parent/guardian Date

<u>Please return signed document to the front desk.</u>
<u>A copy is available for you if requested.</u>