

VILLAGE PEDIATRICS FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please let the front desk know you are here. It is your responsibility to notify the office of any new insurance coverage.
2. We require that all patients maintain a valid credit card on file with us. **Any patient balances that are present after 30 days will be automatically billed on your credit card.** If your credit card is not valid, any balance over 60 days will be forwarded to a collection agency.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you.
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. If our physicians do not participate in your insurance plan, or you have no insurance, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. Co-payments are due at time of service. A **\$25 processing fee** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the next business day.
8. We require 24-hour notice for canceling any appointments. There is a **\$25** automatic charge for missed weekday "sick" appointments and a **\$100** charge for missed weekday physical appointments.
9. There is a surcharge for weekend visits of **\$40** which your insurance company may or may not cover. You are responsible for the charge if it is a non-covered service.
10. A **\$25** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
11. Our office provides an immunization record as well as a chart summary of past medical history free of charge. We charge **\$0.65/page** to copy or transfer all medical records.
12. Advance notice is needed for all non-emergency referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Your primary care physician must approve referrals before being issued.
13. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. If it is not covered, you will be responsible for payment at the time of visit.
14. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
15. **Our "Added Benefits" plan has been a mandatory requirement of the practice since January 1st, 2010.** All families are required to pay by January 7th of each year, or when you join our practice. This modest, per-child administrative fee is for non-covered and non-reimbursed services. It allows us to maintain our electronic medical records, website, emails, and e-prescribing benefits. It will also help us provide personalized and prompt attention to your needs without dramatically increasing our volume, dropping insurance plans, or significantly raising our cash fees. There are no additional fees for the above administrative services. We also continue to offer 24/7/365 access to our providers, without the use of phone triage services.
 - **There is a \$20 discount for paying by December 5th. If you have not paid by January 7th you will be contacted by our office to find out how you would like to pay.**
 - If your family is experiencing a financial hardship, please email us at villagepediab@yahoo.com to arrange an alternative payment schedule. If you are a *new* patient, and you are dissatisfied with our service, we will refund your added benefits if transferring prior to December 31.
 - Many frequently asked questions about our Added Benefits plan are answered on our website, at www.villagepedi.com/added-benefits-plan. Please direct any questions or comments about the added benefits plan to: villagepediab@yahoo.com. A physician or a member of our staff will get back to you promptly.

Please complete the following and return to our office at your earliest convenience.

Name of Parent/Guardian(s): _____

Parent/Guardian of: _____

Financial Policy

I have read and understand the office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined. ***This signature will serve as credit card authorization signature for remaining balances.**

X _____ Date: _____
Parent / Guarantor

Added Benefits Plan

I have read, understand and agree to the Added Benefits plan. I authorize Village Pediatrics to charge this mandatory administrative fee to my credit card. This card will be saved on file for the year.

Please check: 1 child: \$150 ___ 2 children: \$ 250 ___ 3+ children: \$ 325 ___ College Student: \$75___

Name on Credit Card: _____ Card type: _____ Visa _____ MC

Credit card #: _____ Ex: _____ Security Code: _____

Card on file

If the credit card you are using for the Added Benefits Plan payment is **NOT** the card you would like saved on file for co-payments, balances or any other charge, please list your preferred card below.

Name on Credit Card: _____ Card type: _____ Visa _____ MC

Credit card #: _____ Ex: _____ Security Code: _____

Assignment of Benefits

I hereby authorize any physician of Village Pediatrics to apply for benefits on my behalf for services rendered. I request and authorize payment from my insurer to be made directly to such physicians. The insurance information I have reported to you is correct and I authorize the release of any necessary information, including medical information for this or any related claim, to my insurance company. A copy of this authorization may be used in place of the original.

X _____ Date: _____
Parent / Guarantor

Consent to Treat

I (or my legal guardian or parents) authorize Village Pediatrics to provide medical care reasonable by today's standards.

X _____ Date: _____
Parent / Guarantor

HIPPA / Receipt of notice of privacy

I acknowledge receipt of Village Pediatrics' Notice of Privacy Practice, which provides information about how we may use and disclose your protected health information.

X _____ Date: _____
Parent / Guarantor

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