



## FINANCIAL POLICY & WAIVER

Your healthcare is extremely important to us. We are committed to providing you with the highest quality medical care possible in a cost effective manner. We are pleased to discuss with you any questions you may have concerning a bill.

### PAYMENT AT TIME OF SERVICE

- Payment (copayments, coinsurance, and deductibles, etc.) in full is due at the time of service. If you do not have insurance, please come prepared to pay for your visit in full.
- As a courtesy to our patients, we accept *cash, Visa, MasterCard, American Express, money order, and personal checks.*
- We do not accept checks over \$20 or *Discover* cards.
- Failure to pay balances may result in discharge from the practice.

### LET US KNOW OF ANY CHANGES

- Always bring your current health insurance card information to **every** office visit.
- Please notify us at the time of check-in of any changes in insurance, address, phone number, preferred pharmacy, etc.
- ***If the insurance company that you designate is incorrect, you will be responsible for the balance.***
- Your insurance policy is a contract between you and your insurance company. If you have any questions regarding coverage for services, please contact your insurance company.

### MEDICAID

- ***If you have Medicaid and do not disclose any other insurance coverage, Medicaid has the right to reject payment. You will then become financially responsible for the visit.***
- If your child is listed under any other insurance policy, by federal law, that policy is considered the primary insurance and must be billed first. Medicaid is considered secondary insurance and will only be billed after the primary insurance has processed the claim.

### SECONDARY INSURANCE *Additional insurance that may pay some medical charges not covered by primary insurance*

- "Birthday Rule" –In cases where a child is covered by two private insurance policies, the health plan of the parent/legal guardian whose birth month comes first in the calendar year is designated as the primary insurance, according to the National Association of Insurance Commissioners.

### FEES *\*Your insurance will NOT cover any of these administrative fees*

- If your check is returned as a result of insufficient funds, you are responsible for the returned check fees.
- There will be a fee of \$35 for any returned checks.
- If you are more than 15 minutes late for an appointment, you will be marked as a *No Show*. Failure to arrive on time for your appointment will result in a \$25 fee.\*
- 24 hours notice is required to cancel and/or reschedule all appointments. Failure to do so will result in a \$25 *No Show* fee.\*
- All copayments are due at the time of service. Any copayment not received at the time of service will result in a \$10 processing fee.
- Forms needed to be filled out by the physician will result in a \$5 charge. Copies of medical records will result in a \$15 charge.\*
- Forms will be completed in 4-5 business days from the day they are submitted. Please allow 2 weeks for medical records.

### MINOR PATIENTS

- 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 or authorized adult.
- Both parent(s)/legal guardian(s) are responsible for payment for services rendered to the minor patient.

### COLLECTIONS & OUTSTANDING BALANCES

- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. Accounts referred to a collection agency or attorney may be subject to a collection fee of 35% in addition to the total balance due.

### PAYMENT PLANS

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan with our practice. Please note that a ***\$25 non-refundable administration fee will be charged to enroll into payment plans.***
- Please allow 7 mail days after mailing your payment for each payment to be received and posted by our practice.

***Please sign below to acknowledge that you have read and understand Takoma Park Pediatrics' financial policies and agree to be bound by its terms. Takoma Park Pediatrics reserves the rights to change, amend, or modify the policies as deemed necessary.***

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_

(please print legibly)