PENGUIN PEDIATRICS 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 having concerning a bill.

INSURANCE ASSIGNMENT POLICY AND AGREEMENT

We will do our best to accurately verify and file your insurance for services and/or materials, however, benefits quoted by your insurance carrier are not a guarantee of payment. All current insurance and secondary insurance must be provided at the time of service. You are also responsible for any and all co-insurance, deductible and non-covered services on the day service is rendered.

NON-COVERED SERVICES

Should your insurance deny any service or material for any reason, you will be responsible for full payment to us. You may pursue any reimbursement you deem payable directly from your insurance company.

Insurance coverage varies depending on individual plans and contracts, but we have found that some plans do not covered the following:

iScreen(photoscreen): recommended by AAP from 9 months to 4 years, Vision Check, Hearing Screen, Urinalysis, Fluoride, Hemoglobin, rapid flu test, rapid strep test, warts treatment, dressing/wound care, and ear wax removal.

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 respnsible 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.

PAYMENT AT TIME OF SERVICE

Payment (copayments, coinsurance, and deductibles, etc.) **in full** is due at the time of service and within 30 days of receiving the statements by email. Patient are adviced to log-in in to the patient portal to make payments. Failure to make payments on time will result in additional charge of $10 per month. Any balances not received within 60 days will result in additional charge of 50% of the bill. 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 with added convenience of paymen through patient portal. Failure to pay balances may result in discharge from the practice.

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 $10 charge. Copies of medical records will result in a $25 charge.*
- Forms will be completed in 4-5 business days from the day they are submitted. Please allow to 2 weeks for medical records.

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.

COLLECTIONS & OUTSTANDING BALANCES

- Any outstanding balance after 60 days of the date of statement 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%of the bill in addition to the total balance due.

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.

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.

IMMUNIZATION POLICIES

We strictly follow the immunization schedule recommended by the American Academy of Pediatrics. In the best interest of our patinets, we cannot deviate from this schedule. This is to help limit exposure of commnicable disease to patients waiting in our office that may be too young to receive vaccines.

- The child must receive three doses of each of the following vaccines:
  - DTap, Hib, and Prevnar within the first 6 months
  - Polio with the first 24 months
- MMR at 12 months
- Varicella by 18 months
- Hepatitis A and Hepatitis B may be delayed at your own risk; however, we wil require a parent to sign a vaccine refusal form.

If these immunization are delayed in an attempt to avoid vaccinating your child, we reserve the right to dismiss your child from our practice.

By signing this form you are giving us the authorization to keep your credit card/HSA card(mandatory) in our secure system and charge the account with outstanding balances less then $200.

Please sign below to acknowledge that you have read and understand PenguinPediatrics' financial policies and agree to be bound by its terms. Penguin Pediatrics reserves the rights to change, amend, or modify the policies as deemed necessary. This authorization shall be from this date forward, unless written request to revoke is received.

Parent/Guardian Signature____

Revised: 11/08/2017