Financial Policy & Office Procedures

Thank you for choosing Katz Pediatrics and welcome to our practice. We want you to understand our patient payment and office policies in advance so any misunderstanding may be avoided. Our office and physicians' make a great effort to get insurance companies to pay their share of cost in a timely manner. However, due to the recent changes brought on by the Accountable Care Act, this is becoming more challenging and this policy has been revised -**Effective April 1st, 2020.**

By signing below, you accept financial responsibility for all services rendered on your child's behalf whether or not you are present at the date of service. Please note that a divorce decree, separation agreement, or any other financial arrangement between two parties does not release your financial obligation to the patient's account. Although another guardian or adult may provide health insurance for the patient, you are still responsible for all the remaining balances.

(Initial)_____ We will file claims to the participating insurance companies as a courtesy to you- you are and remain responsible for all the remaining balances. We will bill your insurance company only if we are in network, you are responsible for confirming our network status with your insurance plan prior to scheduling an appointment. I understand that I am responsible to provide my current insurance coverage at every visit. I will be responsible for paying any balance as a result of not proving current information. I understand that Katz Pediatrics will not retroactively file claims beyond 90 days due to my failure to provide current insurance information. Katz Pediatrics does not accept secondary insurances.

(Initial)_____ If we do not receive payment form you insurance company within 60 days from the date of service, then you will be billed for the balance in full. We will not file claims more than 90 days from the date of service and you must pay the outstanding balance in full. You are responsible for calling your insurance carrier, at our request, to expedite payment for delayed claims.

(Initial)_____Payment (co-payment, co-insurance, or deductible) is due at the time of service, regardless of who brings the child to the appointment. If your child/children have an outstanding balance, that would be collected at the same time. We are happy to keep your credit card on file should you like. (Our software securely encrypts and stores your credit card information displaying only the last four digits. No employee or outside vendor will ever have access to your information)

(Initial)_____Katz Pediatrics will mail one statement to the address provided to us by you. If your address changes, you are responsible for notifying us. All statements are also available on our secure patient portal. Payment is due upon receipt of the first statement. Patients with an outstanding balance of 30 or more days will incur a late fee of $25.00. Payment plans are available to patients with financial difficulty, however, it is your responsibility to contact our billing specialists to request assistance before the account becomes delinquent. If your account remains unpaid beyond 90 days your account may be turned over to a collections agency. Collections Agency balances require that will no longer be able to provide you healthcare services until the balance is resolved. In the event, the Guarantor agrees to pay any fee incurred by the collections agency.

(Initial)_____ occasionally, during scheduled well visits a physician will diagnose and treat a problem. When appropriate, problems addressed during the preventative exams will be billed as routine care in addition to the scheduled well child visit. Some insurance policies do not cover both services at the same time. In the event that you schedule a well-child exam and a problem is addressed, you may be responsible for an additional co-pay, co-insurance, deductible or denial after the visit.

(Initial)_____We are required by law to accurately report all services received by our patients. Not all insurance plans cover all services we provide. This may include charges for screening forms or routine services such as hearing and vision screening that are required by law or recommend by the American Academy of Pediatrics. Katz Pediatrics follows all recommendations issued by the American Academy of Pediatrics. It is your responsibility to know your benefits before the service is rendered and decline any service you do not wish us to perform. In the event your insurance carrier determines that a service is "not covered" under your policy, you will be responsible for payment. We will not change a procedure or diagnosis code in order for it to be paid.

(Initial)_____Evening, weekend, holiday and walk in appointments are billed at a higher rate. If your insurance company determines this is not covered, you will be responsible for the additional payment.

(Initial)_____I acknowledge that I have received, reviewed, and agree to comply with the Katz Pediatrics No Show Policy and agree to pay any fees incurred from failure to comply. Patients with 3 no-shows will be dismissed from the practice. If you are more the 15 minutes late to an appointment we will do our best to accommodate you but we reserve the right to reschedule your appointment.

(Initial)_____Katz Pediatrics charges a fee for all forms and copies of medical records. I agree to pay prior to the form completion or printing of my child/ children's record.

(Initial)_____All checks that are returned to us will incur a fee of $25.00 service fee. Once a check is returned that you have given us, we will no longer accept a check from you.

(Initial)_____ I acknowledge that routine or annual physicals are an important part of my child's care. Failure to schedule and complete these valuable appointments could result in dismissal from the practice. Katz Pediatrics is a medical home that prides itself on extraordinary care that is not possible without routine wellness exams.

Consent to Treat

As a parent or legal guardian of the patient listed below, I do hereby consent to the performance of routine diagnostic procedures and/or medical treatment as deemed necessary or advisable by my child's physician(s) at Katz Pediatrics. I hereby authorize Katz Pediatrics, PA to apply for benefits on my child's behalf for all services rendered. I certify that the information I have provided regarding my child's insurance coverage is correct. I further authorize the release of any and all information necessary for my child's insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Katz Pediatrics, PA on my child's behalf. I have read and agree to the financial policies listed above. I understand that I am ultimately responsible for the balance of my child's account for all services rendered.

Patient Name_____ DOB_____

Please list all children in the family:

1. Name_____DOB_____

2. Name_____DOB_____

3. Name_____DOB_____

4. Name_____DOB_____

_____ _____ _____ _____

Signature of Responsible Party or Parent Print Name Date Best contact telephone number