SOUTHWEST CHILDREN'S CLINIC, LLC- *OFFICE/FINANCIAL POLICY*

CANCELLATIONS AND MISSED APPOINTMENTS

We appreciate your loyalty and strive to have Well Child and Same Day Sick appointments available for your convenience.

- **Same Day Sick Visits:** Late cancellation is cancelling an appointment **within 2 hours** of the appointment time. A fee of $25.00 will be applied to your account.
- **Well Child Visits or Physicals:** Late cancellation is cancelling an appointment **on the day** of the appointment. A fee of $25.00 will be applied to your account.
- **Missed Appointments:** Not showing up for a scheduled appointment. A fee of $50.00 will be applied to your account.

Please be courteous. If you are unable to attend an appointment please notify us so we may offer your time slot to another family.

APPOINTMENTS AND INSURANCE

Insurance policies and coverage can be confusing and complex based on individual plans. To avoid unexpected charges, it is important that you fully understand your insurance coverage benefits and limitations. Your insurance policy is a contract between you and your insurance company, and we are not able to modify coverage, copayments or deductibles. Having insurance is not a substitute for payment. It is your responsibility to pay the deductible, co-insurance, and any other balances not paid for by your insurance.

- In order to bill your insurance company for services provided, it is critical that we have current insurance information in your records. **We will ask for your current insurance card at each visit to ensure that our information is correct.**
- **Please be aware of your insurance benefits.** Not all services provided are covered by all plans. In all cases, the Guarantor of the account will be charged for any service not covered by the patient's insurance plan. Please feel welcome to ask our billing office if you have questions, however calling your insurance company prior to your visit will leave you, the consumer, most informed.

If your child is being seen for a well check and one of our providers treats your child for: 1. A **sick condition, 2. A follow-up on an existing ailment. 3. Or performs a procedure -**In **addition** to your annual physical, you will be billed a copay, co-insurance or deductible amount according to your insurance benefits.

- Per the contract you have with your insurance company, **copayments are due at the time of service.** A fee of $10.00 will be applied to any copayments not made at the time of service.
- IF you have a deductible, please be aware that we will collect a minimum payment of $100.00 at time of service until you provide us proof from your insurance company that your deductible has been met for the year.
- Physicians are required to follow basic CPT and ICD-9/ICD-10 guidelines when determining how to code services. They must code your visit based upon what services were provided and cannot take into account particular health benefit coverage or a patient's ability to pay. Consequently, we are unable to change the visit reason and diagnosis in order for a claim to be covered by your insurance. If you think an error has occurred, please contact the billing office immediately.

PAST DUE BALANCES AND COLLECTIONS:

- By signing below I agree to pay all amount(s) owed within 30 days of when such amount(s) are incurred. I understand that it is my responsibility to provide my correct/updated insurance information and that this office will bill my insurance as a courtesy to me. However, regardless of insurance coverage, I agree that it is and shall remain my responsibility to pay all amounts owing as set forth herein.
- If you need special payment arrangements, please contact our billing office at 801-563-1980. We are able to provide payment plans for a **maximum** of three months in an emergency situation.
- All returned checks will have a $20.00 charged added to the balance. If the returned check amount is not resolved, additional charges may be applied as per Utah Law.
- In the event any amount(s) is/are referred to a third party debt collection agency, I agree that in addition to any other amount(s) allowed for by law, (such as interest, court costs, reasonable attorney's fees, etc.) I will also be responsible for a collection fee of up to 30% of the principal amount(s) owing as allowed by Utah Code Annotated, sec. 12-1-11 and fees accrued in the process of sending the account to a collection agency. The terms of this paragraph shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.
- **Our collection policies are fair but firm**. We will never deny access to necessary medical services for our patients due to financial issues; however, patients may be discharged from the practice due to non-payment. If a patient is discharged from the practice for financial reasons (including bankruptcy), we will give 30 day notice and provide emergency care during the notification process.

DIVORCED PARENTS:

Southwest Children's Clinic, LLC will not get involved in custodial, separation or financial disputes involving or related to divorced parents of a minor child. The parent who is the guarantor for the insurance policy covering the child is the responsible party. If the child is not covered on an insurance plan the guarantor is the parent who completed the office paperwork.

RESPONSIBILITY STATEMENT:

I authorize the release of all medical information necessary to process each medical claim and all information that is pertinent to my child's medical care. I authorize payment directly to the physician or clinic for all medical or surgical benefits to which my child is entitled. Should any unpaid balance be referred to a collection agency I agree to pay an additional collection fee up to 30% with or without suit. I also agree to pay reasonable attorney fees and court costs should suit become necessary. A photocopy of this assignment is to be considered as valid as the original. I hereby consent to being contacted by telephone at any telephone number provided by me or anyone associated with me or acting on my behalf to Southwest Children's Clinic or anyone acting on its behalf. I understand and agree that such calls may be initiated by Southwest Children's Clinic or any of its affiliates, agents, contractors or assigns, including but not limited to billing companies and/or third-party collection agency(ies), and that the methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automated dialing device and/or the use of text messages—some or all of which may result in data charges. I also consent to receiving e-mails at any e-mail address provided by me or anyone associated with me or acting on my behalf. Utah law requires Southwest Children's Clinic to provide the responsible parties with notice, by certified/priority letter or text message, 45 days prior to placing any delinquent balance with a collection agency or reporting any delinquent balance to any credit bureau, which actions may negatively impact my credit score. I understand I will be charged a fee of $10.00 if any such notice is sent to me.

Patient(s) Name: _____ **Date of Birth:** _____

Parent/Guardian Signature: _____ **Date:** _____

Updated October 2018