2021 OFFICE POLICY ON FINANCIAL ARRANGEMENTS

Thank you for choosing Downers Grove Pediatrics, Ltd. as the healthcare provider for your child(ren). Providing quality medical care for our patients is our primary concern. If you have medical insurance, we will do our best to help you receive your maximum allowable benefits. We must emphasize that as medical care providers, *OUR RELATIONSHIP IS WITH YOU, and NOT YOUR INSURANCE COMPANY*. Times are changing in healthcare, and we need to be sure that patient responsible balances are paid in a timely manner. We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case every time. In order to achieve these goals and make our relationship with you a positive one, we need your assistance and understanding of our payment policy which is described below:

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS:

So that we may bill the insurance company in a timely fashion, it is your responsibility to provide us with *YOUR CURRENT INSURANCE CARD AT EVERY VISIT*. It will be reviewed and copied every time you are here for a visit, *no matter how frequently you are seen*.

YOUR INSURANCE POLICY IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. **We do provide your insurance carrier with information regarding your diagnosis and treatment. We will not become involved in disputes between you and your insurance carrier. Downers Grove Pediatrics is contracted with many different insurance plans. IT IS YOUR RESPONSIBILITY TO CHECK WITH YOUR INSURANCE CARRIER FOR POLICY PROVISIONS AND TO CHECK IF OUR PHYSICIANS ARE CONTRACTED WITH YOUR PLAN. Our physicians provide care according to the *American Academy of Pediatrics* and *NOT* based on what is covered by your Insurance Plan. If a claim is rejected because your insurance does not cover the type of service rendered, *YOU* will be responsible for any balance deemed patient responsibility/non payable/non-covered by your insurance and billed accordingly. If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment.**

Once we determine your personal financial obligation or after your insurance company reimburses Downers Grove Pediatrics for a portion of your care, we will mail you one (1) statement. *PAYMENT IS REQUIRED UPON RECEIPT OF THE STATEMENT*. Any account past due by 30 days will be subject to submission to our collection agency. If your account is placed into our collection process, a 30% collection process fee will be added to your balance, along with any legal fees incurred in this process. *Downers Grove Pediatrics reserves the right to terminate any patient at this point.*

Should you become delinquent on your account and/or end up in collection, *you will also BE REQUIRED to have a credit card on file before you can schedule another appointment.*

AGAIN, IT IS YOUR RESPONSIBILITY TO UNDERSTAND YOUR COVERAGE. THEREFORE, PLEASE EDUCATE YOURSELF AS TO YOUR COVERAGE SO THAT OFFICE VISITS, PROCEDURES, TESTING AND SPECIALIST REFERRALS MAY BE ARRANGED TO BEST SUIT YOUR NEEDS. _____*Initial here*

COPAYMENT POLICY:

COPAYMENTS ARE DUE AT THE TIME SERVICES ARE RENDERED. WE ACCEPT CASH, CHECKS AND ALL MAJOR CARDS. Downers Grove Pediatrics is contracted with many different insurance plans. If your plan requires a co-payment, you will be *REQUIRED TO PAY US THAT PAYMENT ON THE DATE OF SERVICE*. If you are unable to pay your co-payment at time of service, a $25.00 fee will be added to your account. _____*Initial here*

CREDIT CARD ON FILE:

Rather than receiving a monthly paper statement, we are giving you the option to keep your credit on file with our office. We DO NOT store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full. If you would like sign up for this program, please call our billing office. _____*Initial here*

SELF PAY PATIENTS:

Full payment is due at the time of service unless an alternate financial agreement has been made with our Billing Office. We accept cash, personal checks, Visa, MasterCard and Discover. _____*Initial here*

MISSED APPOINTMENTS/NO-SHOWS/LATE FOR APPOINTMENT:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. Please understand that missed appointments have a detrimental impact

on our practice and other patients. They also affect our ability to treat other patients in need of medical care. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you $50.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. Downers Grove Pediatrics reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

If you are more than 15 minutes late for an appointment, Downers Grove Pediatrics reserves the right to reschedule your appointment and refuse to see you at the originally scheduled time. _____*Initial here*

MEDICAID:

Current month's Public Aid card MUST BE PRESENTED prior to service or payment in full is expected. _____*Initial here*

BANKRUPTCY:

Any family filing bankruptcy must pay in full at the time of service. Any insurance payment will be refunded. Charts will be copied for transfer to another physician if you cannot comply with this policy. _____*Initial here*

REFERRAL POLICY:

If your Insurance company requires a referral, it is your responsibility to contact our Referral Coordinator to obtain the proper documentation. We require *5 day notice* for referrals. _____*Initial here*

PARENTAL SEPARATION:

The person who brings the child in for treatment is responsible for payment of any co-pay or balance. IF THERE IS A DIVORCE SITUATION, THE PARENT WHO BRINGS THE CHILD TO THE OFFICE IS THE PERSON RESPONSIBLE FOR THE CHARGES. *WE WILL NOT BECOME INVOLVED WITH THE PARTICULARS OF YOUR DIVORCE*. We will provide a receipt so that the responsible party can reimburse them. *WE WILL NOT BILL THIRD PARTIES FOR PAYMENT OF BALANCE DUE.* _____*Initial here*

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Downers Grove Pediatrics to: (1) release any information necessary to insurance carriers regarding patient's illness and treatments; and (2) process insurance claims generated in the course of examination or treatment. This order will remain in effect until revoked by me in writing. _____*Initial here*

ACKNOWLEDGEMENT

I have received the practice's Medical Authorization for Release/Disclosure of Protected Health Information/HIPPA Privacy Notice.

If you have any questions regarding your account at any time, please contact our Billing Department. Should you have any other issues, please contact our office manager.

I have read and agree to the terms of this financial policy.

NAME: _____ DATE: _____

Person Financially Responsible (Print)

_____

Signature