Updated 07/2018

ABC Pediatrics of Asheville, PA
Financial Agreement and Policies

Thank you for choosing **ABC Pediatrics of Asheville, PA** as your Pediatric provider. We are committed to providing you with quality health care. We have developed this payment policy to help answer questions you may have regarding the payment and insurance responsibility for services rendered. Please read it, ask us any questions you may have, sign in the space provided, and return to us. A copy will be provided to you upon request.

Proof of Insurance and Eligibility

You must present your insurance card **at EACH visit.** Phreesia will attempt to access eligibility, co-pay, co-insurance, and deductible information. We will also ask to verify your insurance and scan your insurance card upon **EACH** visit to our office. If you do not have current insurance information, **you will be required to pay for the services rendered until a copy of your current insurance card is obtained. We charge $100.00 for a sick visit and $200.00 for a well check visit.** We also encourage each family to call and find out their specific benefits for their policy because it is ultimately your responsibility to know and understand your own insurance coverage.

Insurance Participation

We have **contracts** with and file claims for the following insurance companies: Aetna, BCBS, CIGNA, Crescent, GEHA, Medicaid, United Health Care, Golden Rule, UMR, Healthscope, Healthgram, Humana, Federal Blue Cross, and Medcost. We can provide you with information to file your insurance if you are out of network. You will need to check with your individual policy to see if we are in network with your particular carrier or if the service you need is covered.

Assignment of Benefits

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. **I hereby authorize** and direct my insurance carrier(s) to issue payment check(s) directly to ABC Pediatrics of Asheville, PA rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Claims Filing

We will file claims for those insurances with which we are contracted, as well as secondary insurance. We accept the contractual write-off based on your primary insurance. Once we have received instruction from your insurance company, you will receive a bill for any outstanding balance. You will then be responsible for that balance. We can provide you with information to file your own insurance if we are not in contract.

Non Covered Services

It will be the responsibility of the family to know your benefits. You will be responsible for non-covered services. Some common services that are not covered are the afterhours charge, developmental screen, vision, hearing test, and depression screen.

Keep us informed

Most often errors in billing and claims payment are related to incorrect information. Please update us with name, address, email address, phone number and insurance information as it changes.

Payment

We accept Checks, Cash, Discover/Visa/MC/American Express and Debit cards. We also accept Care Credit. You may pay your **co-pay** or previous **balance** on the **Phreesia** tablet while checking in for your visit. All payments for service are **due on the day the service is provided**, unless other arrangements are made with our business office 828-277-3000 X 324. You will be required to **store a credit card** on file for future payments. By agreeing to store your card, if you have future charges, our office will only charge your card up to $100 per visit and no more than $500 per 365 days. Your card will remain on file for 1 year, and will only be charged for YOUR part of the bill. You may apply for **Care Credit** on our website. We also offer online payments on our website on the home page at www.abcasheville.com.

Self Pay Discount

We offer a self-pay discount of 30% if you do not have insurance to file. The visit must be paid on the **same day** as the patient's service is rendered. We do not allow patients who have insurance to use the self pay discount as an option if you have high deductible or high copayments.

Co-Payments

Many plans require that a patient pay a co-payment at each visit. We are bound by our contracts with insurance companies to collect that co-payment at the time we render our services. In keeping with our contracts, we will collect your co-payment when you check in. Please help us in upholding the law by paying your co-payment at each visit. We will charge **$10.00** for each co-payment that is not paid on the date of service. This will be added to your monthly statement.

Co-Insurance, Deductibles and Statements

To avoid collection issues and increased billing, we will collect any percentage of the co-insurance or deductibles not met at the time of service. These amounts are calculated based on our negotiated fee schedule with the insurance company. Once your statement reflects that your insurance has paid you must pay your portion for that date of service. . You will **receive only two statements**. If payment is not made after the second statement, you will receive a collection letter. We reserve the right to terminate our patient relationship for non-payment of services.

Check In and Proof of Identity

Check in is now performed on a Phreesia tablet. All patients must complete patient information, demographics and clinical information before seeing the doctor. You will receive a reminder email 3 days prior to your visit and may complete your check in online. You can even complete all questionnaires online. Mention that you have previously checked in to the receptionist. You must provide us with a

current copy of **your insurance card at each office visit**. We may also ask you to provide us with a copy of your driver's license or other photo ID. Due to Insurance filing we do require the social security numbers of both parents. Also parents or legal guardians must be present for office visits of a minor.

Patient Refunds

Refunds will be reviewed on a per claim basis. Upon confirmation and approval of refund, check will be issued to account holder or credit refunded to your card.

Returned Checks

We charge a $25 fee for returned checks. Patients who have written more than one returned check will be required to pay by cash or credit card. Multiple returned checks may result in discharge from the practice.

Delinquent Accounts

We will make attempts to contact you by phone, email and by mail regarding delinquent accounts. Failure to pay will result in accounts being turned over to our contracted collection agency in 90 days from the date of service. If your account is turned over, we will no longer offer medical care to the guarantor of the account or any family members for whom that guarantor is responsible. We will see your family for 30 days after termination date, for sick visits only. This will allow your family time to find another provider for medical care. If your account is turned over to collections, a $25.00 fee will be assessed.

Charge for Medical Records

Medical records requested will be copied for the following fee: $15.00 for 20 or more pages, per family.

Night/Weekend Charge

We charge an additional $45.00 for our services on holidays, weekends and also in the evenings after 5:30 P.M. check your insurance coverage for this charge.

Custody/Payment Issues

Due to the many complicated issues that arise due to custody and payment issues, it is our office policy that payment is expected by which ever parent is bringing the child to the appointment. The parents can then work out an agreement for repayment amongst themselves.

Walk-in Clinic

Our office offers a walk-in clinic on a first come first serve basis. Our walk-in clinic starts at 7:45 and continues until the physicians are assigned a total of four patients each. Each morning we have a different number of physicians here to see walk in patients. Also, you may or may not see your primary physician. Once the physicians are all assigned four patients, the walk-in clinic is full. If you are unable to be seen at the walk-in clinic we will be more than happy to schedule an appointment for your child later on in the day, depending on availability.

Weekend Clinic

We offer a weekend clinic that is by appointment only. (No walk-ins allowed) Appt Hours: 1:00 P.M.-5:00P.M. The clinic is used for acute sick visits only due to limited number of appointments. Nurse triage is available at 12:00 to begin taking phone calls and scheduling appointments for the 1:00 time slot.

Night Clinic

We also offer a night clinic that is also by appointment only. (No walk-ins allowed) Appt Hours: 6:00 P.M. - 8:00 P.M. This clinic is also used for acute sick visits only due to limited number of appointments. Please note that night clinic appointments will not be scheduled until 4:00 P.M.

Forms

Please allow **5 days** for completion of any type of medical form.

No-Shows/Cancellations & Late Appointments

Please give our office 24 hours advanced notice of cancellation so that we may offer that appointment to another patient. If you are more than 15 minutes late for your appointment you may be required to **reschedule** to a later date. If your child has more than three no-shows we will terminate care to your family. We would continue to provide medical care for sick appointments only for 30 days, providing you time to locate another primary care physician. There will be a fee of $25.00 added to your account for **a no show.**

Inappropriate Behavior

ABC Pediatrics strictly prohibits verbal or physical abuse or threats of any kind to our physicians, nursing staff or office staff. This type of behavior will lead to immediate dismissal from the practice.

Cell Phone and Video Recording

To ensure confidentiality and privacy, any type of electronic recording is strictly prohibited when interacting with medical staff. This includes pictures and videos.

By signing below or by electronic signature, I agree that I have read the above financial agreement. I understand and agree to adhere to the policies included within this agreement.

Patient/Guarantor Name: _____

Pt. /Guarantor Signature: _____

Date: _____ Account# _____