Piedmont Pediatrics Financial Policy Name: _____ DOB: _____

Please sign and date

We are committed to providing the best possible healthcare for our patients and we look forward to serving you and your family. To continue to do this, we must remain financially responsible, which includes seeking payment for services provided. We do our best to openly and clearly share our financial policies knowing that it will help us work together successfully. Please let us know of any questions you have about our policy. Thank you.

Payment or payment arrangements are required at the time services are provided. Verified health insurance coverage is considered a payment arrangement. If it is determined that your insurance coverage is not in effect at the time of service or you have insurance with which Piedmont Pediatrics does not participate, payment is expected at the time of service. There is a charge associated with every visit and, upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment.

Insurance: We participate with many, but not all, insurance companies. Our current insurance partners are listed on our website. We only file claims with our participating insurers. We cannot file for secondary coverage when we don't participate with the primary insurer. It is your responsibility to verify that we participate with your insurance plan and to understand your plan benefits, limits, and requirements including referral requirements and coverage limits, especially for items such as imaging, lab work, and specialist or emergency room visits. After your insurance claim has been processed, you are responsible for any remaining balance including uncovered services. Your current health insurance and personal demographic information must be updated annually and whenever it changes.

Copay Policy and Billing Fee: Per the contract you have with your insurance company, copayments are expected at the time of service. There is a $10 fee to bill you for the copay. This charge is not billable to your insurance company and is your responsibility.

Newborns: Congratulations! During this especially busy time, we want to make sure that you know you must contact your health insurance provider immediately to add your child to your policy. For most insurers, this must be done within 30 days of your child's birth. We are unable to file insurance claims for newborns until they are added to your policy, and you have provided us with proof of coverage.

Divorce and Separation Decrees: Piedmont Pediatrics is not a party in divorce or separation decrees or in child support arrangements. We bill one guarantor, at one address, and expect prompt payment. We do not handle billing or insurance coverage disputes between parents.

Billing, Collections and Bankruptcy: Payment in full is due upon request and is expected with the first bill. When a second bill for the same date of service is sent, a fee of $10 is added to your account. If you are experiencing ongoing financial hardship, we encourage you to talk with our billing department so that we can work together to establish acceptable payment arrangements. When your account is not paid in a timely manner, your child may be turned away for non-emergent services until the balance is paid. If your account remains unpaid, it may be sent to an outside collection agency or attorney. For accounts sent to collections: You are responsible for any and all collection, agency and attorney fees associated with collection, and you will be given a 30-day notice of discharge from our office, which means you would need to find a different pediatrician for your child. Please understand that if you include debt owed to us in a bankruptcy filing, your account will be closed, and you will be given a 30-day notice of discharge. We much prefer to work out acceptable payment arrangements and continue to provide care for your child so please talk to us before filing.

Forms of Payment and Returned Checks: We accept cash, check, and American Express, Discover, MasterCard and Visa credit cards. If your check is returned to us by the bank, a $50 return check fee will be added to your account.

Lab Work: Some healthcare insurance policies restrict which lab they cover. We are not responsible for out-of-network lab costs. We currently send labs to Sentara, LabCorp or University of Virginia but that may change without notice. It is your responsibility to know the lab that is in network for your policy and inform us of restrictions prior to lab work being done.

Referrals: If your insurer requires a referral for imaging, specialists or other visits, our referral specialist can help arrange it for you. Referrals must be requested at least 72 hours in advance.

Extended Hours Fee: As a service to our patients, we have extended hours beyond those traditionally offered by a doctor's office. Any holiday, weekend or evening care visit after 5pm is charged the same fee as we do during regular office hours with the addition of an Extended Hours Fee of $25. Not all insurance plans cover this fee.

Uncovered Services: This paragraph fulfills any "prior notification" requirement your insurance carrier may require contractually of our practice regarding any and all uncovered services. Please read it carefully. Each health care plan and insurance policy has services that it specifically excludes. Some examples are standard of care or screening tools recommended by the American Academy of Pediatrics (ASQ/MCHAT, EPDS and PHQ9), Fluoride Varnish, Spot Vision screening, and Extended Hours Fee (CPT 99051). There is often no consistency in their rulings, and each patient/family must read the "fine print" of their own policy. By requesting or receiving a service, a patient (and guarantor) hereby agrees to be personally responsible for payment of uncovered services. Uncovered services are immediately payable in full.

Missed Appointment Policy and Fee: This fee is billed when you do not notify us 24 hours in advance of a cancelled appointment or fail to arrive within 15 minutes of a scheduled appointment. The fee ranges from $50 to $100 depending on the amount of time that was reserved for your appointment due to the reason for your visit. This charge is not covered by insurance and is your responsibility. Every attempt is made to provide a reminder for appointments scheduled over a week in advance; this is a courtesy only and has no effect on your financial obligation for a missed appointment.

Rush Form Fees: We spend a surprising amount of time completing routine forms for school, camp, and sport participation. We do not currently charge for this service. We suggest making a copy of your completed form in the event it is lost. A Rush Fee of $20 is charged when form completion is needed in less than three business days.

Medical Record Fees: Please refer to our Records Release form for an explanation of these fees.

I understand and agree with the Piedmont Pediatrics Financial Policy:

X_____

Guarantor (Patient or Parent/Guardian for minor patients) **Date**

Release of Information and Payment Authorization: All Insurance Companies, Third Party Payers and Government Policies: I hereby authorize Trusted Doctors, PLC, dba Piedmont Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the provider(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Trusted Doctors, PLC, dba Piedmont Pediatrics. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered. I certify that the information given by me in applying for payment is correct.

Guarantee of Payment: I am responsible for the payment of all charges for services rendered by Piedmont Pediatrics, and I understand that filing claim with my insurance company or other third-party payer does not under any circumstances relieve me from my responsibility for payment. By signing this document, I personally guarantee the payment of these charges. This includes, but is not limited to, claims filed for Worker's Compensation and/or claims due to personal injury accidents/illnesses. I agree that this authorization is valid for all children for whom I am responsible, until rescinded in writing or replaced by one of a later date.

X_____

Guarantor (Patient or Parent/Guardian for minor patients) **Date**

_____

Relationship to Patient