

Our Patient Payment Policy as of January 2009

Pediatric Gastroenterology Associates

Thank you for choosing our practice! We are committed to offering you the best possible medical treatment and care. Please understand that payment of your bill is part of this treatment and care.

All patients must complete our *Patient Information*. We believe that a good relationship is based on understanding and open communications. Our staff has been instructed to make every effort available to you to clarify any misunderstanding you have concerning your balance.

For your convenience, we have answered a variety of commonly-asked financial policy questions below. If you need further information about any of these policies, please ask to speak with our Billing Specialist or the Practice Manager.

How May I Pay?

We accept payment by cash, check, VISA, and MasterCard. For your convenience, our billing office is staffed Monday through Friday from 8:30 AM to 4:30 PM. The phone number is 678-474-1117.

You are expected to make payment in full upon receipt of a billing showing your balance due or according to the terms below:

Balance Due

\$100 or less
\$101-\$500
\$501-\$1000
\$1,001-\$5,000

Terms

Payment in full within 30 days
2 Months
4 Months
12 Months

Other payment plans or options may be available upon completion of a financial statement analysis. Please contact our Patient Financial Services for this information and/or when your billing address changes. A monthly billing charge of \$ 20.00 will be added to all accounts not paid in full within 45 days of service.

When is my account delinquent?

An account is considered past due 30 days following billing unless other arrangements have been made. Unpaid accounts beyond **90 days** are considered delinquent and may be forwarded to our collection agency.

How are my Medicine Refills handled?

Our policy is for the patient to call their pharmacy and ask them to **fax** the request for your medication to 678-474-1116 Attn: Nurses Station. All requests are usually handled within **48 business hours**. Processing times may vary depending on the availability of your doctor, who for your safety must review each request prior to completion.

Are there Service Charges?

We will assess a \$ 25.00 returned check fee.

Excessive calls for prescriptions will encounter a service charge of \$ 25.00 per occurrence.

There will be a billing fee of \$20.00 added to each statement, billed after 45 days of service.

What are My Responsibilities When Providing Insurance Information?

We expect all Insurance information to be complete and accurate. . Incomplete or incorrect insurance information given to us (example: omission of Primary/Secondary Insurance Carrier or responsible party) will delay claims filing and can in some cases result in no payment for services rendered. We will charge a **\$ 100.00** fee for any incomplete insurance information resulting in such a delay!

Is Interest Charged?

Patients with an outstanding balance over 60 days will be charged interest of **20%**.

Extra copies of Medical Records:

We will charge a \$ 25.00 handling fee for any chart copies. Please allow 48 - 72 hours turn around time.

Phone calls to Doctors

Our physician does not conduct telephone medicine. If you need to talk with the doctor we will gladly give you an appointment. Calling the doctor after hours or requesting phone consultation will result in a charge which insurances do not pay-making you responsible. Charges vary depending on length of phone conversation:

1-15 minutes: \$ 50.00
16-30 minutes: \$ 75.00
31-45 minutes: \$ 100.00

Do I Need A Referral?

If you have an HMO plan with which we are contracted, you need a referral authorization from your primary care physician. If we have not received an authorization prior to your arrival at the office, we have a telephone available for you to call your primary care physician to obtain it.

If you are unable to obtain the referral at that time you will be rescheduled or you will have to pay for the visit out of pocket. We will **NOT** refile any insurance claims if payment has been made out of pocket due to no referral.

What Is My Financial Responsibility for Services?

Your financial responsibility depends on a variety of factors, explained on the following pages. Claims which have not been paid in 60 days will be automatically billed to you. We can, however, assist you in refilling your insurance at your request.

What about missed appointments?

We would appreciate your help and courtesy of a call if you are unable to keep an appointment. Please notify our office at least twenty-four (24) hours prior to the appointment time. We reserve the right to charge you a missed appointment fee of \$ 25 for office visit and \$ 50.00 for procedure no show. Three (3) missed appointments are grounds for patient discharge.

Legal Fees:

Any patients sent to collections, will be responsible for all collection fees. If a patient is taken to small claims court the patient will be responsible for all fees/charges.

Assignment of Benefits

You need to assign benefits/payments for your insurance payments to the doctor.

Emergencies after hours

If you need medical care when the office is closed, please go to the nearest Emergency Room.

You Have...	You Are Responsible For...	Our Staff Will...
Commercial Insurance Also known as indemnity, "regular" insurance, or "80%/20% coverage."	Payment of the patient responsibility for all office visit, x-ray, injection, and other charges at the time of office visit.	Call your insurance company ahead of time to determine deductibles and coinsurance. File an insurance claim as a courtesy to you.
HMO & PPO plans with which we have a contract	If the services <u>you</u> receive are covered <u>by</u> the <u>plan</u> : All applicable co-pays and deductibles are requested at the time of the office visit.	Call your insurance company ahead of time to determine co-pays, deductibles, and non-covered services for you

What If My Child Needs To See The Doctor?

A parent or legal guardian must accompany patients who are minors on the patient's visit. This accompanying adult (who consents to the treatment) is responsible for payment of the account, according to the policy outlined on the previous pages. We will not be involved in separation/divorce disputes.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility.

I authorize my insurance benefits be paid directly to Pediatric Gastroenterology Associates.

I authorize Pediatric Gastroenterology Associates to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Date

Printed Name

Signature:

Witness 1 Signature:

Witness 2 Signature: