Watoto Pediatric & Adolescent Specialty, LLC

OFFICE FINANCIAL POLICY

Watoto Pediatric & Adolescent Specialty is committed to providing the best total care of your children. Our goal is to provide and maintain a good provider-patient relationship. Don't hesitate to let us know if we are achieving our goal. Please read this carefully.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. This is your verification of the correct insurance and consent to bill them on your child's behalf. ***If the insurance company that you designate is incorrect, you will be responsible for payment of the visit and submission of the charges to the correct plan.***

2. Make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.

3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. Co-payments are due at time of service. A **$25 processing fee (or service fee)** will be charged in addition to your co-payment if the co-payment is not paid at time of service or by the end of the business day.

4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. ***You are responsible for any balance on your account.***

5. It is your responsibility to understand your benefit plan and to know if a written referral or preauthorization is required prior to a procedure, and what services are covered.

6. If our office does not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, all balances must be paid before the visit.

7. If you have no insurance, payment is due at the time of the visit.

8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due ***within*** **10** business days of your receipt of your bill.

9. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a $25 re-bill fee. Any balance over 60 days will be forwarded to a collection agency.

10. We require 24-hour notice for canceling any appointments. There is a **$75** charge for well-child and extended visits if they are not canceled, and **$35** for all other visits.

11. You may be charged a fee for complex problems that require prolonged telephone conversations with the physician and for after-hour calls that are non-emergency. Remember to call 911 for all life-threatening emergencies.

12. A **$35** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

13. We charge **$20** per child to copy or transfer medical records.

14. If your child has school, camp, or sport forms to be completed, there is a **$10** charge per form. Payment is due when the forms are dropped off. We have a 4-day turnaround time for forms. If a form is needed sooner than 4 days, there is an additional **$10** *rush* fee.

15. Advance notice is needed for all non-emergent referrals, typically 5 to 7 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.

16. Before making an annual physical appointment, check with your insurance company to see if the visit will be covered as annual physical. Not all plans cover annual physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.

17. Not all services provided by our office are covered by every plan; payment for these services will be your responsibility. Check with your insurance provider prior to the visit.

I have read and understand Watoto Pediatric & Adolescent Specialty's financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) ______________________________

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Responsible party's name Relationship

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Responsible party's signature Date