

Tuscaloosa Pediatrics Financial and Office Policies

_____ Please be aware if you are a new patient and fail to show up for your 1st appointment without giving a 24 hour notice, you may be asked to find another medical office or physician for medical care.

_____ Please be aware our office does not accept all insurances. You may be asked to transfer out of the practice if you change to an insurance we do not accept, change to a plan we are no longer participating with, or our enrollment for your insurance is full at that time.

_____ All professional services rendered by Tuscaloosa Pediatrics, P.C. are charged to the patient. We will gladly file your insurance for you. However, the parent or guardian is responsible for all fees that are not covered by the insurance.

_____ We are required to report visits outside of normal business hours to your insurance provider. Any appointment scheduled before 8am, after 5pm, and on Saturday or Sunday will incur an additional fee. This fee will be billed to your insurance provider, but may be applied to your copay, coinsurance, or annual deductible.

_____ Payment is due at time services are rendered (such as co-pays, deductibles and non covered services) regardless of who brings the patient in for his/her visit. There will be a \$15.00 administrative fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, and MasterCard.

_____ We feel strongly about children having routine well check-ups. Per American Academy of Pediatrics, children should receive preventative health care at the ages listed below. We expect our parents to follow these guidelines so that we may continue to provide quality healthcare to our children. We understand there are some insurance policies that do not cover yearly check-ups, but do not feel this is a reason for your child not to have them. Failure to do so may result in being discharged from the practice.

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| - 3-5 days of life | - 6 months of age | - 24months of age |
| - 2 weeks of age | - 9 months of age | - 30 months of age |
| - 1 month of age | - 12 months of age | - 3-18 years of age - yearly |
| - 2 months of age | - 15 months of age | |
| - 4 months of age | - 18 months of age | |

_____ If your child is not current on routine check-ups, any refill on chronic medications and/or any routine immunizations may be denied until your child is current on routine check-ups.

_____ No well visits or immunizations will be given if you have an outstanding account balance.

_____ It is the patient's responsibility to know your insurance benefits and whether the physicians in this practice are preferred providers. Some insurance companies require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours if you are seeing or have seen another physician. Don't assume that referrals are done if you don't speak to someone in our insurance office, even if our physicians or nursing staff refer you.

_____ We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance, for a life-threatening emergency or we instruct you to go because we are unable to schedule an appointment here in a timely manner.

_____ Most insurance companies allow 30-45 days for you to add your newborn to your insurance policy. We require you to pay for the visit in full for the 2 month check-up if we cannot verify your baby's enrollment before the visit.

_____ We must have a release signed by a parent or guardian on file to release medical records. We request your account be paid in full in order to release your medical records if you are transferring your child/children to another physician. Accounts that are not paid in full or arrangements made to do so will be treated as a bad debt and will be forwarded to a collection agency.

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_____ There is a fee and a 72 hour waiting period on all medical forms, blue cards not associated with a check-up and medical record copying. Please check with the office staff in advance on the cost for each request.

_____ There is a \$15.00 fee for after hours telephone calls. Please read and follow our Telephone Policy to avoid unnecessary costs.

_____ Excluding refills on chronic medications, any prescription not associated with an office visit with one of our providers may be subject to a \$15.00 fee.

_____ If you do not cancel your appointment 24 hours prior to the scheduled appointment time, you will be charged a No Show/Failure to Cancel fee. Any office visit that is scheduled with a Physician will incur a \$40.00 No Show/Failure to Cancel fee. Any visit scheduled with a nurse will incur a \$10.00 No Show/Failure to Cancel fee. Repeat offences could result in being discharged from the practice.

_____ If you have not arrived to your appointment within 15minutes of your scheduled appointment time, we will assume you are not coming. In such case, you will be charged the missed appointment fee.

_____ There is a \$25.00 fee on all returned checks.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits

I acknowledge that, at my request, Tuscaloosa Pediatrics, P.C. has provided my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and if my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand the collection agency charges Tuscaloosa Pediatrics a 33 1/3% fee in an effort to collect outstanding balances. This fee will be added to my bill and become my responsibility.

I hereby authorize Drs. Brown, Cunningham, McGiffert, Parchman, Vaughn and Kaila Sullivan, CRNP to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the physicians all payments for the medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Communications Regarding My Account

Until my account is finally settled, I give my direct consent to receive communications regarding my account from any servicers and any collectors of my account, through various means such as 1) any cell or text number that I provide, 2) any email address that I provide, 3) auto dialer systems, 4) voicemail messages, and other forms of communications.

Patient Name

Patient Date of Birth

Signature

Relationship

Date