CAMELBACK PEDIATRICS, P.C. MEDICAL SERVICES FINANCIAL AGREEMENT & HIPAA NOTIFICATION

Insurance

In order to help you receive your maximum insurance allowable benefits, we need your assistance and understanding of our payment policy. Understand that we do our best to obtain benefit information from your insurance, but we have limited access due to the multiple plans available by each insurance carrier. Additionally, they tell us the information is not a guarantee of benefits. Ultimately, you will need to know your benefits to ensure proper coverage.

You will be asked to update your personal and insurance information every 12 months or as information changes. We will require a copy of your insurance card in order to bill your office visit appropriately. We are required by law to obtain your signature for permission to release information to your insurance carrier. Our failure to obtain these updates could result in criminal and civil penalties and/or expulsion from your insurance plan.

We will gladly submit fees for your covered medical services to your insurance company. However, we expect payment of all services within 30 days. **It may become necessary for you to pay your account in full if your insurance company fails to pay for services within 30 days, or if they deny the claim.** It is your responsibility to understand your coverage and benefits, including if we are in network with your plan, precertification, referral and authorization requirements. We will, however, assist you to ensure that all plan requirements are met.

Initials: _____

Payment for Services

Payment for services, including copayment and deductible amounts, is due at the time services are rendered unless payment arrangements have been approved by our billing staff. We accept cash, checks, MasterCard, Visa and Discover. Our failure to collect these amounts is a violation of our contract with your insurance company and may result in civil and criminal penalties and/or expulsion from your insurance plan. In addition, your failure to pay the required co-amounts is a violation of your financial responsibility for coverage and we may report your refusal to pay these amounts to your insurance company.

If you cannot furnish an insurance card at the time of the visit, you will be responsible for payment in full at the time of service. It is not the responsibility of our office to obtain this information for you. We will be happy to supply you with an accounting of the visit so that you may submit the information to your insurance company for reimbursement.

Returned checks will result in a $25.00 fee that will be posted to your account. Returned checks, balances older than 60 days, and failure to pay account balances as promised will be subject to external collection and additional collection fees, including attorney and other court fees. We may investigate your credit record to determine your ability to pay your debt.

Initials: _____

General

We will gladly discuss your proposed treatment and answer questions relating to your insurance. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract. We must emphasize that as medical providers, our relationship is with you, not your insurance company.

Please be advised that if you are scheduled for a routine well visit, but also have health issues to have evaluated at the same time, we will need to bill your insurance for both the well visit code and the evaluation of the services OUTSIDE the scope of a routine physical.

We do require at least 24 hours notice for cancellation and rescheduling of any appointment. A $30.00 no show fee may be applied to your account for **EACH** missed appointment if you fail to come in for your appointment. (e.g., two children scheduled at the same time will be charged $30 each for both missed appointments.) If you have 3 no show appointments in a calendar year, you will be discharged from the practice. You will then have to make arrangements to establish with a new doctor.

Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date the services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Initials: _____

Receipt of Notice of Privacy Practices

I have been offered the HIPAA Notice of Privacy Practices which outlines my privacy rights and how Camelback Pediatrics, PC may use and disclose Protected Health Information about me. □ Yes □ No □ Offered but Decline ***Initials:*** _____

My signature below constitutes acknowledgement and acceptance of these policies.

Parent Name: (Please Print) **Parent or Guarantor Signature:**

_____ _____ **Date:**_____