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North Arlington Pediatrics, S.C.
Financial Policy

At North Arlington Pediatrics, SC (NAP), we believe that all patients who are rendered care at our office deserve the best medical care that can be provided. The following information is provided to help you understand your financial responsibilities, as well as the policies and procedures of North Arlington Pediatrics. Please read, sign and date this agreement on the last page to indicate you accept these terms.

Insurance Coverage

It is your responsibility to provide accurate insurance information at the time services are rendered. Our office policy is to request your insurance card at every visit to guarantee that our office staff has the correct information at all times.

NAP will submit claims to your insurance carrier on your child's behalf. It is your responsibility to verify benefits under your plan. ***Your insurance policy is a contract between you and your insurance company***. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, co-insurance and non-covered charges. Please contact your insurance carrier, not North Arlington Pediatrics, if you have questions about the insurance coverage or payment. **If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment.** You are responsible for timely payment on your account.

We are required by our insurance contracts to collect all copays at the time of service. Failure to collect applicable copays put both of us in default of the insurance contract. The parent or guardian accompanying the patient is responsible for all copayments and non-covered services at the time of service. **If the copay is not received within 7 business days of the initial date of service, a $10.00 administrative service fee for processing your copayment after your visit will be added to the account.**

Once your insurance company has processed your claim, our business office staff will post any payment it receives to your account. For every charge submitted, the insurance company issues an Explanation of Benefits (EOB) to the policyholder and North Arlington Pediatrics. If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved in writing by the business office, the balance on your statement is due and payable when the statement is issued and is considered past due if not paid within thirty (30) days of issuance. If you have questions regarding the coverage or payment from your insurance carrier please call them with any questions, not North Arlington Pediatrics.

Change of Insurance/Change of Address

Please notify the business office as soon as possible of all insurance and address changes. The responsible party (parent or legal guardian) is responsible for all charges not paid as a result of change in insurance coverage.

Payment Options

Our office accepts Visa, MasterCard, Discover and American Express. We also accept cash or checks. Checks returned unpaid by your bank, regardless of the reason, will be posted back to your account in the original amount of the check in addition to a $25 returned check fee. Once we have a returned check, we may require all future payments be with cash, money order or credit card.

Newborns

It is your responsibility to contact your insurance carrier to have your newborn child added to your insurance within the first week of birth, if not sooner, as dictated by the insurance carrier. You understand that failure to do so will jeopardize your child's ability to be insured. You will provide North Arlington Pediatrics with your child's health care coverage information immediately upon receipt and within thirty (30) days of birth to assure timely billing. You understand that failure to contact your insurance carrier will result in your child not having health care coverage and you will be financially responsible for all medical services rendered by North Arlington Pediatrics.

Uninsured/Self-pay Accounts
We offer a discount to all self-pay patients and payments must be made on the date of service. If you do not make payment on the date of service, full prices will be applied to that visit.

Parental Divorce

The parent who carries the insurance will be responsible for all uncovered services, unless North Arlington Pediatrics is in receipt of a court order or letter stating otherwise from the party requesting financial designation. The parent or guardian accompanying the patient is responsible for providing North Arlington Pediatrics with current demographic and contact information for both parents. If the demographic information for the parent responsible for the insurance cannot be provided, the other parent/guardian will become the responsible party until proper information is received. The parent accompanying the child to the visit will be responsible for copays unless otherwise stated by court order or written agreement by both parents. You will be responsible for the charges accrued by minor children (under age 18) who come into the office unaccompanied, or in the presence of another caregiver (i.e. grandparents, baby-sitter, etc.)

Missed Appointments/No Shows/Late for Appointment
We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Missed appointments are cost to us, to you and to other children who could have used the time set aside for your child. Cancellation or re-scheduling for a Well Visit is required 24 hours in advance and cancellation for a sick visit is required at least 1 hour prior to the scheduled appointment. A charge of $50 will be assessed and must be paid prior to making another appointment. If you are more than 20 minutes late for an appointment, North Arlington Pediatrics may have to re-schedule your appointment. Recurrent missed appointments are ground for dismal from our practice.

Medical Records
Copies of medical records are available to the patient or authorized representative for a fee as allowed by law. You will need to complete the authorization to release records form, which can be obtained from our office. This form needs to be completed in its entirety for us to process the request. Please allow two weeks lead time for records. All patient account balances should be paid in full before records are transferred. Your first set of medical records are processed at no charge, if an additional set is required, you will be charged the allowed fee by the State of Illinois.

Forms
Due to the increasing costs of providing our patients with the highest standards of care, we may impose a charge for certain forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. We will automatically give you a school/camp/sports/daycare form at the time of your child's physical. Please keep the original and photocopy it for anyone requesting a health form. If you require the office to provide an additional form before your next scheduled physical exam, there may be an administration fee of $10.00 to be paid at the time of pick-up or over the phone payment if we are faxing or emailing it. Forms such as FMLA, Disability or Supplemental Insurance forms will be $15.00. Dictated letters, extensive forms with review of medical records may be $25.00 per page.

Assignment of Benefits
I request that payment of authorized Medicaid and commercial insurance benefits be made on my behalf to the name of provider of service (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicaid, private insurance and any other health/medical plan, to issue payment check(s) direct to North Arlington Pediatrics, SC for medical services rendered to my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

Authorization to Release Information
I hereby authorize North Arlington Pediatrics, SC: (1) release any information necessary to insurance carriers regarding my dependents illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by North Arlington Pediatrics, SC.

Acknowledgement and Acceptance of Financial Policy

I have read and understand the policies of North Arlington Pediatrics, SC Financial Policy. I agree that I am financially responsible for any professional services rendered regardless of insurance coverage. I also agree that if it becomes necessary to forward my account to a third-party collection agency due to nonpayment for medical services rendered, in addition to the amount owed, I will also be responsible for the fee charged by the collection agency and all related collection expenses. By signing below, I acknowledge that I have received a copy of the North Arlington Pediatrics Financial Policy, have read it and agree to its terms.

_____
Name (printed clearly)

_____ _____
Signature of Parent or Legal Guardian Date

Name of children seen at our practice. **PLEASE PRINT CLEARLY**

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____

Name _____ Date of Birth _____