WEST ALABAMA PEDIATRICS

Insurance and Office Policies

All professional services provided by West Alabama Pediatrics are charged to the patient. We file most major insurance companies. Please contact your insurance company and verify that we participate in your group plan. It is the patient/parents responsibility to make sure we have the correct insurance information on file. We will gladly file your insurance for you. However, patients are responsible for all fees regardless of the insurance coverage.

All co-pays, deductibles and non-covered charges are due at the time of service, regardless of who brings the patient in for his/her visit. In cases of divorce or separation, where each parent is responsible for a portion of the bill, we do not "split" account balances. There will be a $10.00 billing fee added to your account if your co-pay is not paid at the time of service. We accept cash, check, Visa, MasterCard, American Express and Discover.

You should receive a statement on your account by the first of every month. We expect our patients to pay their account balance in full. Please notify our office manager immediately if you have unusual financial circumstances and need to make special financial arrangements. We are willing to work with you on an arranged payment plan. An account that is delinquent for more than 90 days will be sent to collections, and any costs incurred thereby will be the responsibility of the patient (parent of responsible party). If your account is turned over for collection, we may no longer continue to provide medical care for your child. No well visits or immunizations will be given if you have an outstanding account balance or if you have not made arrangements for your account to be paid in full.

It is the patient's responsibility to know your insurance benefits and whether the physician you see is or is not a preferred provider. Some insurance require referrals to specialists and urgent care facilities. It is your responsibility to notify our office within 48 hours during normal business hours if you are seeing or have seen another physician. We will not give referrals to urgent care facilities or emergency rooms if you go during our regular business hours unless approved in advance or is considered an emergency.

You have 30 days to add a new baby to your insurance. Please contact your HR department and make sure your baby is added to your policy before the baby's first visit to our office. If we are unable to verify coverage, you will be responsible for paying the office visit in full.

In order to release medical records, we must have a release signed by a parent or guardian on file. There is a fee for copying of medical records that includes $1.00 per page for the first 25 pages and .50 for each page thereafter. In order to release your medical records to another physician for the purpose of changing physicians, we request that the balance of your account be paid in full. 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.

There is a fee and a 48 hour waiting period on all medical forms, including blue cards (immunization record) not requested at the time of a check-up. A form fee list and price is posted at the front desk.

There is a $10.00 fee associated with after hour's telephone calls. Please read our Telephone Policy to avoid unnecessary costs. There is a $30.00 No Show/Cancellation fee if you do not call and cancel your appointment 24 hours prior to the scheduled appointment time. There is a $30.00 fee on any returned checks.

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

I hereby authorize payment directly to West Alabama Pediatrics for the medical services rendered to myself or my dependents. I hereby authorize West Alabama Pediatrics to furnish medical information to my insurance carriers for payment of claims. I understand that the charges occurred at each office visit are for my continued healthcare. I understand that I am financially responsible to the physician for charges not covered by my insurance company. 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 agree to pay 28% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

_____I_____I_____

Signature of Parent or Guardian **Relationship to Child** **Date**

Effective 3/17/17