MIDDLETOWN PEDIATRICS PATIENT FINANCIAL POLICY

INSURANCE INFORMATION

Primary Insurance Plan Name:_____ Effective Date: _____
Policy Holder Name: _____ Date of Birth: _____
Social Security #_____
Mailing Address (if different from patient): _____
Relationship to Patient: ☐Parent ☐ Legal Guardian ☐ Foster Parent ☐Self ☐Other: _____

Secondary Insurance Plan Name:_____ Effective Date: _____
Policy Holder Name: _____ Date of Birth: _____
Social Security #_____
Mailing Address (if different from patient): _____
Relationship to Patient: ☐Parent ☐ Legal Guardian ☐ Foster Parent ☐Self ☐Other: _____

NOTICE OF FINANCIAL RESPONSIBILITY

BILLING GUARANTOR

The parent and/or legal guardian who signs this document understands that any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status are due at the time of service.

INSURANCE PLANS

We must emphasize that as a medical provider, our relationship is with you the patient, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. Your insurance is a contract between you and your insurance company, and we are not a party in that contract.

1. It is your responsibility to understand your benefit plan and what services are covered, as well as referral and outside laboratory requirements. **INITIAL _____**
2. It is your responsibility to keep us updated with your correct insurance information. Should the insurance company you designate be incorrect, you will be responsible for payment of the visit in full and to submit the charges to the correct plan for your reimbursement. This includes secondary plan coverage. **INITIAL _____**

REFERRALS

It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.
It is your responsibility to know if a selected specialist, reference lab, or outpatient facility participates in your plan.

INITIAL _____

COVERED/NON-COVERED SERVICES

Middletown Pediatrics in not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover. I acknowledge that I am responsible for any balance that may be due to Middletown Pediatrics as a result of:

Co-Insurance or Co-payments	Annual Deductible amounts	Out-Of-Network Charges
Non-Covered Services	Exhausted Benefits	Pre-Existing Conditions
Immunizations & Routine Benefit Restrictions		Terminated Coverage
Failure to Update coordination of Benefits		

INITIAL _____

INSURANCE ASSIGNMENT AND RELEASE

I authorize Middletown Pediatrics to submit insurance claims on behalf of the patient either by standard claim form or electronic claim processing by the office or a third party. I authorize any holder of medical or other information about the patient, including information concerning treatment of psychiatric/psychological conditions, drug and/or alcohol treatment or related conditions and HIV or AIDS related conditions, to release any information necessary to process claims with any insurance carrier(s). I hereby assign and authorize payment to Middletown Pediatrics, LLC of all benefits for services filed with my insurance carrier(s). A photocopy of this authorization shall be as valid and effective as the original.

INITIAL _____

SELF PAY/UNINSURED

We offer a timely payment discount from our standard fees on some services as a courtesy to our uninsured patients. We do require payment in full at the time of service.

DIVORCE/CHILD CUSTODY

Middletown Pediatrics will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since Middletown Pediatrics is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements.

In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at Middletown Pediatrics is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then Middletown Pediatrics will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, Middletown Pediatrics will

provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

I understand that unless I notify Middletown Pediatrics in writing, along with supporting documentation, that Middletown Pediatrics will assume the patients' biological and/or legal parents are each legal guardians who may bring patient in for treatment and have access to the patients' medical history and plan of treatment, including the patients protected health information.

INITIAL _____

APPOINTMENTS

1. Middletown Pediatrics values the time we have set aside to see and treat your child. If you are not able to keep an appointment, we require a 24-hour notice. There is a charge of $25.00 for (med check/sick visit) and $50.00 for (Well Visit), "no show" appointments. This fee is not covered by insurance and is your responsibility.

   I understand that I will be responsible for a $25.00- $50.00 no show fee if I do not cancel my appointment within 24 hours of the appointment. I also understand that my insurance will not cover this no-show fee and I will be responsible for the charge.

INITIAL _____

2. If you are more than 15 minutes late for your appointment, we will do our best to accommodate you, however on certain days it may be necessary to reschedule your appointment.
3. We strive to minimize any wait time; however, emergencies do occur and will take priority over a scheduled visit. We appreciate your understanding.
4. A lot of times our patients may come in for their yearly well check and during the course of the discussion with the provider and/or results from routine labs we may need to discuss an issue that does not fall under a WELL CHILD visit; this also includes the prescribing/managing of medication(s). Should this occur we are legally bound to manage these issues. We then have to bill for two separate visits, but for the same day. This will most likely result in a copay for that portion of the visit. We strive to keep these visits separate to avoid confusion, but Middletown Pediatrics will always put patient care first.
5. I understand that a <u>legal parent/guardian MUST accompany the child</u> to the following appointment types:
   a. Initial Office Visit
   b. Administration of Immunizations
   c. Well exams (annual physical, sport or camp physicals)
   d. Medication follow ups

FORMS

If there are forms to be filled out or copying of records not required by law or by your insurance company, we may charge a reasonable fee according to Kentucky guidelines for such services. You will be notified before we complete the task if a fee will be assessed. Such fee will be due upon completion of the requested forms and/or record copying.

- There is a $20.00-$25.00 fee for all FMLA and disability forms.
- There is a $15 fee for all requested letters generated by Middletown Pediatrics
- Middletown Pediatrics will happily complete any and all school, sport, and camp related forms at the time of service. After the date of service any generated form will be a $10.00 fee.
- Lengthy documentation request fees will vary on the complexity of the request and providers' time.

FINANCIAL RESPONSIBILITY

We accept cash, checks, most bank cards, and most major credit cards. A $50.00 fee will be charged for any checks returned for insufficient funds. Should you have a check come back for insufficient funds, all future payments must be cash or credit card.

Our office makes every reasonable effort to collect payment from insurance companies and patients. Once these efforts are exhausted, we may report unsatisfied accounts to a collection agency of our choice for payment and credit reporting. Before an account is sent to collections, any applied but unearned discounts may be reversed. Additional expenses, usually 30% of the amount sent to collections, are incurred, and subsequently added to the patient's balance. Unresolved accounts may be referred to court mediation. If you have an account that is referred to our external collection agency your credit may be negatively affected.

I understand that if my account is sent to collections, I will incur additional expenses, usually 30% above my original debt.

INITIAL _____

TRANSFER OF RECORDS

If you transfer to another physician, we will transfer a copy of your records to that physician within 30 days. We will provide you with 1 free copy of your records. Any additional requests will be subject to a fee of $1.00 per page plus postage. Should we have already sent your records to our off-site storage facility you will also be responsible for the $25.00 fee involved in retrieving and refiling of those records.

I have read this Financial Policy and have had the opportunity to ask questions about it. I understand and agree to this Financial Policy.

_____ _____ _____

Patient's Printed Name Signature of Patient or Responsible Party Date