

FINANCIAL POLICY

Panhandle Pediatric Group, PA

Welcome to Panhandle Pediatric Group! We want to ensure the timely management of your account and help you in obtaining reimbursement from your insurance company. To accomplish this, we need your understanding and acceptance of our financial policy.

PARTICIPATING PROVIDER

We are providers for a select group of major PPO networks and the Medicare program. However, due to the complexity of managed care plans, it is difficult for us to know the details of each patient's plan. **Therefore, it is your responsibility to ensure that your physician and ancillary providers are participating providers in your plan. You should verify this information by contacting your insurance plan or reviewing your provider list before making an appointment.** You will be responsible for payment in full for services rendered by your physicians if he/she is not a provider in your plan. We will try our best to inform you of changes in our provider status as they occur.

For Non-PPO plans or traditional "80/20" plans, we will file a claim as a courtesy, however, the contract with your insurance company is between you and the company. Family Medicine Centers is not a party to that contract. You are ultimately responsible for your bill, regardless of any non-payment by the insurance carrier. If within 45 days, payment is not received by your insurance company; payment will be due by you, regardless of the status of your claim.

CO-PAYMENTS

We require your co-payment at the time of service. The co-payment specified on your card will be collected. If the co-pay amount is not listed on your card, or you have a standard "80/20" plan, we will collect 20% of the services rendered. You must have met your deductible in full in order for co-payments of 20% co-insurance to be accepted.

YOU MUST PRESENT A VALID INSURANCE CARD AT THE TIME OF SERVICE IN ORDER FOR US TO FILE A CLAIM FOR YOU.

DEDUCTIBLE

Our office will verify that you've met your deductible prior to services being rendered. If you have a high deductible and it is likely that the services rendered will go toward your deductible, we would appreciate payment in full at time of service.

PRECERTIFICATION OF HOSPITAL ADMISSION OR SPECIAL SERVICES

Precertification of hospital admissions and other special services is an area we strive to help you with. With the exception of some HMO plans, it is ultimately the patient's responsibility to inform us when precertification is a requirement of your plan. Due to the varying policy provisions of all of our patient's plans, it is impossible for us to know each patient's specific plan provisions. **If you fail to disclose precertification requirements PRIOR to service being rendered, you will be responsible for payment of all related fees in full.**

FOR OUTPATIENT AND INPATIENT SERVICES PROVIDED OUTSIDE OF OUR OFFICE, IT IS YOUR RESPONSIBILITY TO BE AWARE OF AND *INFORM* US OF WHICH MEDICAL FACILITIES ARE APPROVED BY YOUR PLAN, THIS INCLUDES X-RAY, LABORATORY, DIAGNOSTIC AND REHABILITATION FACILITIES.

SECONDARY INSURANCE

We will file ONE secondary insurance for you as a courtesy. If no payment is received by your secondary plan within 45 days, you will be responsible for the balance.

RESPONSIBLE PARTY (GUARANTOR)

It is not the policy of Panhandle Pediatric Group to become involved in medical bill payment disputes resulting from divorce. The guarantor is the adult who brings the child in for treatment, regardless of any court decisions or insurance coverage. The guarantor will be given a receipt for payment which they may pursue reimbursement by another party. If someone other than the guarantor brings the child in, that person will be required to pay for services rendered and they will be given a receipt.

LIABILITY OR AUTO ACCIDENT CLAIMS

Panhandle Pediatric Group does not become involved in automobile or liability lawsuits, nor do we file liability claims or wait on “settlements”. You will be required to pay in full for services rendered. W will provide you with the information necessary to be reimbursed.

BILLING OF ACCOUNT BALANCES

You will receive a statement for which payment is **due upon receipt**. If your statement reflects and “insurance balance” your claim is still pending payment. If your statement reflects a “patient balance”, this is the portion for which you are responsible. We strongly recommend your active involvement in the management of your account. When you receive your statement, compare it with your insurance explanation of benefits to ensure that the balance is correct. If payment has not been received by your insurance company, contact them. In this way, we can work together to ensure insurance companies honor their part of the agreement.

PAYMENT PLANS

We understand that from time to time unexpected circumstances may arise which make paying for medical care difficult. With this understanding, we provide payment plans to assist you in the management of your account. You may contact a patient account representative at 806-358-9400, to arrange for this service.

NSF CHECKS

We utilize the services of **ReCheck** for nay NSF items received. Once returned, these items are handled directly by **ReCheck**. When we receive 2 NSF checks on your account, we will accept only cash for future visits.

NON-PAYMENT OF ACCOUNTS

Accounts for which we are unable to collect the balance due will be referred to an outside collection agency. We also reserve the right to report this activity to a nation al credit-reporting agency. Each physician reserves the right to discontinue patient care for non-payment or non-compliance. In this instance, a sufficient prior notice will be given and records provided.



ACCEPTANCE OF FINANCIAL POLICY

The undersigned hereby certifies that he/she has read, understood and agrees to the financial policy of Panhandle Pediatric Group.

_____ **Signature of Patient or legal Guradian**

_____ **Date**

ASSIGNMENT OF BENEFITS

The undersigned hereby request that payment form authorized insurance carrier or state benefits program be made directly to the Panhandle Pediatric Group physician who rendered services on their behalf for the period of: LIFETIME. The undersigned also releases the disclosure of medical information for use in obtaining reimbursement by an authorized insurance carrier.

_____ **Signature of Patient or legal Guradian**

_____ **Date**