VIP PEDIATRICS FINANCIAL POLICY

VIP PEDIATRICS is committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your VIP PEDIATRICS financial account, please:

- Supply all necessary information for the accurate billing of your claims, including your insurance card, employer information, and demographic information. Please update any changes to this information promptly.
- Satisfy all insurance co-payments, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and VIP PEDIATRICS with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
VIP PEDIATRICS does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE
Indemnity/Fee for schedule for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement when asked by you so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or reasonable and customary charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

I do ___ do not ___ currently have Medicaid insurance (please check one)

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
Each time you make an appointment with VIP PEDIATRICS it is your responsibility to make sure that Dr. Wolens is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. *Please plan to show your current card at each visit.*

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- **I have read and understand that I am personally responsible for payment on this account.**
- **Assignment: I hereby authorize payment directly to VIP PEDIATRICS or Dr. Jeoffrey K. Wolens. Any changes in this authorization must be received in writing within thirty days of the effective date.**
- **I understand that this practice has a No-show Appointment fee of $20.00 for first no-show., increasing by $20 for every no show in the family I am responsible for paying this fee if I do not cancel an appointment with 24-hours notice. If 3 no-shows occur for a family, no further appointments will be made and all your children will be discharged from the practice.**
- **A Returned Check fee of $30 will be charged for any check returned for insufficient funds.**
- **Basic School, Camp and Sports and other forms will be assessed $10 per form to complete (fee waived if completed at time of well visit or sports exam).**
- **Complex Forms requiring detailed explanations or calculations with be assessed $25 per form to complete. We require 24 hours to complete these forms.**
- **Requests for "Rush", ie. same day or required in less than 24 hours, form completion not done at time of well visit will be assessed the form charge plus an extra $25 per form.**
- **In the event my insurance company deems a service to be non-covered, I understand that I am personally responsible for payment.**
- **I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of the effective date.**
- **Phone calls, portal messages and email questions may be assessed charges as allowed by insurance coding.**

Print Name: _____ Date: _____

Guarantor Signature: _____ Relationship to Patient: _____

PATIENT(S) NAME: _____