PATIENT FINANCIAL POLICY, Effective July 21, 2025

The last several years have seen profound changes in health care reform. It has therefore become necessary to implement the following policies.

PLEASE READ THROUGHLY AND SIGN THIS SHEET

We will bill you for any copays or deductibles that you may owe once we receive an explanation of benefits from your insurance company. If you fail to receive an EOB or EOP from your plan within 45 days of treatment, we suggest you contact your insurance plan to determine benefits, as they may not have made payment. Payment not received in 60 days may be transitioned to patient responsibility, and you may be required to make other payment arrangements.

CO-PAY, COINSURANCE: We are required by our insurance contracts to collect all co-pays and other patient responsible amounts at the time of service. Please be prepared to pay at check-in. To assist you, we accept cash, checks, credit cards, or debit cards, and HSA cards. You may receive a bill for a copay for an annual wellness exam if there was an additional issue addressed, such as new concerns, chronic condition management, or diagnostic testing.

DEDUCTIBLES: If you have not met your deductible, you may receive a statement with additional balances after your visit. Please make sure you understand your deductible and which services may apply. You can contact your insurance company for additional information.

SELF-PAY PATIENTS: Self-pay patients are required to make a deposit at the time of service during check-in.You may contact the billing department for a quote for your visit, which includes a 35% self-pay discount. If additional charges are accrued for testing or vaccines, you must pay for the charges before leaving the office.

RETURNED CHECKS: There is currently a $40.00 fee for any checks returned by the bank. We have the right to adjust this amount at any time.

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy is to charge $150.00 for missed appointments. This includes behavioral health, nutrition, and lactation appointments. We will not file with, nor will the insurance plans pay for this charge. Please help us serve you better by keeping, or canceling in advance, all scheduled appointments.

PATIENT PAST DUE ACCOUNTS: Past due accounts may result in collection action. We encourage patients to set up interest-free payment plans, and all balances are expected to be paid within 12 months. We reserve the right to discharge patients from the practice for nonpayment of financial obligations.

LAB/X-RAY/DIAGNOSTIC SERVICES: You may receive a separate bill for medical care, which includes lab, x-ray, or other diagnostic services from another facility. You are financially responsible for any co-pay or balance due for these services if they are not reimbursed by your insurance. These services may be put towards your deductible.

STATEMENTS: If you have a balance on your account, we will send you a statement. It will show separately the previous balance, any new charges to the account, and any payment or credits applied to your account during the month.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued. It is considered past due if not paid within 60 days.

INSURANCE RELEASE: You understand that your health plan may not be liable for service rendered if any of the following conditions apply:

- You have a pre-existing condition or other diagnosis that may not be covered by your plan;
- Our practice does not participate in your health plan;
- You have not met the deductible under your health plan contract;
- Well child check-ups, immunizations, adult or sports physicals, as well as other routine services, may not be covered by some insurance plans.

Remember that we must receive your billing information at the time of each visit in order to meet the claim submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information to process your claim, you will be held responsible.

We will not be held liable for ensuring the accuracy of your insurance information, including, but not limited to, verifying current coverage and eligibility, obtaining authorizations, or confirming co-pay,coinsurance,and/or deductible information. Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred.

DIVORCE: In case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect funds from the other parent.

ON-THE-JOB INJURIES/ACCIDENTS: If the reason for your visit is an accident or injury while on the job, please know that we will submit the bill directly to your employer or your employer's workers' compensation carrier. The bill

will not be covered unless your employer files a claim to the carrier – it will remain your responsibility until a valid claim is filed by your employer.

MOTOR VEHICLE ACCIDENTS: If the reason for your visit is a motor vehicle accident, please know that we will submit the bill directly to the vehicular insurance. We require the name of the insured or policy holder, the name and phone number of the insurance company, the claim number, and the name and phone number of the adjuster. The bill will not be covered unless the policy holder files a claim to the carrier – it will remain your responsibility until a valid claim is filed.

COPIES AND TRANSFER OF RECORDS: You may be charged a base fee of $15.00 for each transaction. Additionally, we may charge up to $0.50 per page for the copying costs of the first 100 pages of medical record, and $0.25 per page in excess of 100 pages.

EFFECTIVE DATES: Once you have signed this agreement, you agree to all of the terms and conditions contained herein for this and any future visits, and the agreement will be in full force and effect.

To summarize, your financial responsibility pertains to:

- Denied and non-covered services;
- Services deemed not medically necessary by your insurance company;
- Co-payments, deductibles, and co-insurance;
- Pended claims due to lack of patient and/or guarantor information;
- Non-Insurance and/or out-of-network benefits.

Always bring your current health insurance card to the office. Notify us of any changes in insurance, address, telephone, or family status at time of check-in. Pay your co-pay or deductible balance and co-insurance amount at the time of service. You will be expected to pay in full if:

- You do not have insurance;
- Our practice does not participate with your health plan;
- You are unable to present a valid member identification card from your insurance carrier at your visit; or
- We are unable to verify your insurance coverage.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, please be aware that some, and perhaps all, of the services provided may be non-covered services under your plan, and you will be 100% responsible for these charges. The following are your responsibilities:

- Ensure our providers actively participate with your insurance carrier;
- Know your and your dependents benefit coverage, prior to receiving services;
- Remember to make sure that all individuals on your policy have the correct primary care physician selected at your insurance company as this is the number one reason why claims are denied;
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

I have read and understand Pediatric Associates of Greater Salem & Beverly's Financial Policy. I agree to assign insurance benefits to Pediatric Associates of Greater Salem & Beverly whenever necessary.

Signature of insured or authorized representative: _____

Date_____