PEDIATRIC PARTNERS OF NORTHERN KENTUCKY
FINANCIAL POLICY

Pediatric Partners *of* Northern Kentucky

We are committed to providing your children with the best possible care and treatment. If you have medical insurance, we are eager to help you receive the maximum allowable benefits. To achieve this goal, we need your understanding of your insurance benefits and our financial policies.

Payments: Co-payments, deductibles or co-insurances are due at the time service is provided. A current insurance card must be presented at the time of service. If your insurance contract requires a co-pay or co-insurance, it will be collected before your child sees a provider. If your insurance contract requires a deductible, we will collect $75 at the time of service and the remaining balance is due 30 days from the invoice date. Many deductible plans cover well child care in full and for those visits no payment will be collected at the time of service. We will ask that the parent bringing the child into the office pay the co-payment, deposit, and/or outstanding balance at the time of the visit. We will not bill or split the bill for the other parent at any time. Statements are sent to one parent, and they are free to forward copies on to the other parent. If your divorce decree or custody documents state a split on who is responsible for medical expenses, this is an issue to take up with your attorney. We ask that payment be made to us, and you will be responsible to seek reimbursement from the other parent.

Insurances: We attempt to be in-network with most all insurance companies in our area that allow. However, it is your responsibility to make sure that we are part of your plan. If we see your children and you discover after the fact that we are not in-network the balance will remain your responsibility. At this time we will not accept any medical "share" policies that claim to help with healthcare costs through your church. Our experience is that nothing is ever "covered", and no payments are ever made. We will submit the claim for you but payment is expected at time of service and we will not be able to bill you later.

Claims: For your convenience we will file your insurance claims. Claims are usually processed within 30 days. Our billing department will make every effort to collect payment from your insurance company, but if all attempts fail it is your responsibility to contact the insurance company. If a claim becomes more than 90 days old you may be asked to pay the claim while you contact your insurance company. Once payment is received from the insurance company we will refund the amount back to you. If the amount is less than $40 we will keep this credit on your account for you to use the next time you are in. If you ever want us to refund that amount to you, just contact the billing department and they will issue you a check within one week. Not all services are a covered benefit in all contracts. Therefore, it is your responsibility to understand the benefits of your insurance policy. Most insurance companies require that claims are submitted within 90 days of date of service. If for some reason we have not received the most updated insurance information from you and the claim did not go to the correct insurance provider you will be responsible for payment in full.

COB: (Coordination of Benefits) Insurance companies now frequently require that you respond to their requests to verify that they are the only insurance that you have. When these requests are not completed insurance companies deny payment for all claims for that patient. Please be sure to respond to those requests as soon as possible. If we receive a denial for COB we will send an email to you to verify your COB with them and ask them to release the claims. It is important to do this as quickly as possible so that the claims are paid accordingly.

Balances not covered by insurance are due in full within 30 days of receiving a statement unless other arrangements have been made. If your balance goes over 90 days past due and you have not responded to our attempts to contact you, we will be forced to send your account to a collection agency. Should this occur, you agree to assume responsibility for any fees, interest, and services charged by the collection agency, and we will be forced to terminate the patient/physician relationship.

Returned checks will carry a service charge of $25.00.

Appointments not cancelled 24 hours in advance will be charged a $25.00 non-cancellation fee per appointment. These charges are not billable to insurance. We understand that true emergencies do arise, if you call the day of your appointment and inform us you will not be able to keep your appointment, allowances may be made. If more than 3 visits are not cancelled 24 hours in advance, you will be dismissed from the practice.

Please read and sign below:

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I have read all the above information and understand it fully. I will notify this office of any changes in medical insurance or any other personal information that I have provided on the registration forms. I certify this information is true and correct to the best of my knowledge.

I hereby authorize the physician to furnish information to the insurance carrier concerning medical services rendered. I also authorize the insurance carrier to make payments directly to this office. I understand that I am responsible for any amount not covered by insurance. I agree to pay all balances due in full within 30 days of receiving a statement unless arrangements have been made in advance with our billing department.

SIGNATURE_____ PRINT NAME:_____

CHILD(RENS) NAME(S)_____DOB_____

NAME_____DOB_____

NAME_____DOB_____

NAME_____DOB_____

NAME _____DOB_____

NAME _____DOB_____

NAME _____DOB_____

NAME _____DOB_____