OUR PATIENT FINANCIAL POLICY

Thank you for choosing Rainbow Pediatrics to provide your care. We are committed to your successful treatment. We recognize the need for clear understanding regarding financial arrangements for medical care, and therefore, the following is a statement of our Financial Policy, which we require you to read and sign prior to your visit. All patients must complete our patient information and insurance form before being seen by the doctor.

Insurance Coverage

We accept assignment from many insurance companies, however in the event your insurance does not cover your treatment within a reasonable time, the balance will be transferred to the guarantor's responsibility. Please be aware that some of the services you receive may be non-covered services or considered not medically necessary under Medicare and/or other medical insurance. We will make every attempt to notify you when a service may not be covered; however, due to numerous rules with different insurance companies it is not possible for us to always know when the insurance company may make a determination to disallow payment for a service.

I understand that Rainbow Pediatrics will make every attempt to notify me when services may not be covered by my insurance. Upon determination by my insurance, I will be responsible for any services not covered. **Initials**: _____

We must emphasize that our relationship is with the patient, not your insurance company. While we make every attempt to provide the insurance company with the information necessary to process the claim, it is your responsibility to provide correct information about your insurance for us to coordinate your benefits, verify you were eligible for coverage at the time of service, and to address claims your insurance company denies. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are ultimately your responsibility. You must notify us of any insurance changes ***before*** your visit so we can ensure we are in-network and the bill is forwarded to the correct insurance company.

I understand that I am responsible to provide accurate insurance information to Rainbow Pediatrics or to coordinate benefits as requested by my insurance company. I also understand that if my benefits are ineligible at the time of service I will become responsible for the amount due. **Initials**: _____

Rainbow Pediatrics is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. All copays and deductible amounts owed are due at time of service. If your insurance applies any portion of the charge to your deductible or coinsurance, that portion is due and payable by the guarantor. We expect prompt payment of this balance. Your employer or provider of insurance determines the patient's benefit coverage, not us. If we are outside your network, please check with your insurance regarding non-network benefits coverage. It is your responsibility to understand your coverage. If you have questions regarding your coverage, please speak with your company representative.

I understand that I am responsible for payment at time of service for all copayments, deductibles and other out of network services. Initials: _____

I understand that if my insurance changes to Medicaid without notifying us in advance, you w ill be 100% responsible for the charges that were incurred on your behalf. **Initials**: _____

If your insurance requires designation of a primary care physician (PCP), you are required to have a prior authorization from your PCP and insurance company prior to your visit. If this authorization is not provided you will be asked to reschedule your appointment or pay for your visit at time of service.

Self Pay / Uninsured

We may offer a timely payment discount from our standard fees on some services as a courtesy to our uninsured patients. We may require payment in full for services not medically necessary. Evaluation and Management, or office visit fees are due at time of service.

Missed Appointments/No Shows

You will be charged a $50.00 fee for any appointment you do not show up for or do not cancel at least 24 hours in advance. In order to provide the best possible service and availability to all our patients, we ask that you keep all your appointments, but we also understand things come up and therefore ask that you inform us as soon as you can about your change in plans. This fee is not covered by insurance but is your responsibility, and it will need to be paid before your next visit or service.

I understand that I will be responsible for a $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. **Initials:** _____

Other Services

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 Ohio 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.

After Hours Triage - $25.00
Complex Form Fee - $40.00
Complex Pre Authorizations - $50.00
Emergency Referral - $50.00
Return Check Fee - $35.00
Standard Form Fee - $10.00
Telephone Consultation - $50.00
Travel Consultation - $75.00

I understand that I will be responsible for these additional charges should I need these additional services provided by the practice. **Initials:** _____

You may also receive a separate bill for services performed outside our office, such as labs, imaging, etc. Questions regarding those charges should be directed to the appropriate external service provider.

Payment Details

We accept cash, checks, money orders, most bank cards, and most major credit cards. We reserve the right to process your payment electronically based on information you provide to us. Returned checks must be resolved before any future appointments can be scheduled. We reserve the right to refuse any personal check and to require another form of payment at our sole discretion.

Minor Aged Patients

Parents or guardians are responsible for payment of any fees not covered by insurance for a minor. For unaccompanied minors, treatment will be denied unless we have received the proper paperwork.

Credit Balances and Small Balance Write Offs

Occasionally an overpayment is made and a refund is due to the patient. Unless you object, credit balances will be applied to any existing or new balances on your account or held to cover future services already scheduled. If after six (6) months the credit still exists and there are no future services scheduled, all unapplied credit balances over $10.00 will be refunded to the patient. If a refund is due to insurance, this will not change the amount due from the patient for "patient responsible" balances. Similarly, we will hold balances under $10.00 that are due to the practice on account for this same 6 month period and if no future services are scheduled we will write that amount off under our small balance write off policy. The small balance policy does not pertain to any government payer or patient covered by a government program.

Account Delinquency and Credit Reporting

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 35% 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 35% above my original debt. **Initials: _____**

I have read this Financial Policy, and have had 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

_____
Staff Witness