Alzein Pediatrics Financial Policy

We are committed to providing you with the best possible care. If you have medical insurance, we wish to help you receive your maximum allowable benefits. To achieve this, we need your understanding of and assistance with our financial and payment policy.

Insurance: For your convenience, we will submit your claim and assist you in any way we reasonably can to get your claim paid. Insurance plans vary considerably and we cannot predict or guarantee what part of our services will or will not be covered. It is your responsibility to know your individual policy and to verify all benefits and coverage information prior to having services rendered. Your insurance policy is a contract between you and your insurance company.

Initials:_____

Proof of Insurance: Proof of insurance must be shown at check-in at every visit. Without proof of insurance, you will be charged for the visit in full.

Initials:_____

Change of Insurance/Change of Address: Please notify the office as soon as possible of all insurance and address changes. If the guarantor does not notify the office within 15 days of any changes the guarantor is responsible for all charges not paid because of change in insurance coverage.

Initials:_____

Newborns: Most commercial insurance companies allow only 30 days to add your newborn to your plan. Please do so as soon as possible. All newborn bills will be held and sent to the insurance company once it can be verified that the newborn has coverage. By 2-months of age, all babies without proof of insurance will be expected to pay in full for their 2-month well visit and all visits since birth.

Initials:_____

Self-pay: We do everything we can to mitigate the expense of anyone who is uninsured. Alzein Pediatrics provides a discount for self-pay patients. Payment is expected in full at the time of service for all charges.

Initials:_____

Co-Payments: We're contractually obliged to collect, and you're responsible to pay, your co-payment at the time of your visit. Please have your co-payment ready at check-in.

Initials:_____

Deductibles & Coinsurance: Depending on your insurance policy, a deductible or coinsurance may be required at the time of service. Once the co-insurance amount has been established, the amount due at each visit will be the coinsurance percentage of the charges incurred, plus any deductible not yet met for the year.

Initials:_____

Outstanding Balances: Any amount not covered by the insured/patient's insurance is due within 30 days of the time of service. Balances on account must be paid prior to receiving additional services. Accounts will be turned over to a collection agency if past due 60 days or more. The patient family will be responsible for all collection costs involved with the collection of this account including court cost, reasonable attorney fees and all other expenses incurred with collection if there is a default on any unpaid balance. **Should you have extraordinary financial pressures, we will assist you with a payment plan, agreed to in writing with our billing department prior to services being rendered.**

I nitials:_____

Credit Card on File: Alzein Pediatrics is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. If a credit card is not available, we require a $200.00 retainer fee that will be applied towards any patient responsibility as determined by your insurance. Your card number will be saved in a secure PCI compliant site separate from the electronic medical recp. Credit cards on file can be used to pay copays and other charges at the time of the visit. The stored credit card would be used for payments toward patient responsibility, which is determined by your insurance company, unless the amount due is paid in full within 14 days of the statement.

Initials:_____

Coordination of Benefits: Responsible parties must respond to a request for information from the insurance within 10 business days. A failure to respond to a request for COB information from the insurance will result in all charges becoming patient responsibility.

Initials:_____

Cancellations: Our office charges a $25.00 no show fee for missed well/routine appointments. If you need to cancel your well/routine appointment, please contact us at least 48 hours in advance. This charge is not covered by your insurance and is the responsibility of the parent/legal guardian.

Initials:_____

Divorce: In the 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 from the other parent.

Initials:_____

Transfer of Records: Should you wish to transfer care to another physician, you will need to complete the authorization to release records form, which can be obtained from any of our clinic locations. This form needs to be completed in its entirety for us to process the request. All balances should be paid before records are transferred.

Initials:_____

The doctors at Alzein Pediatrics contract with most insurance plans. However, it is my responsibility to understand the benefits provided in my insurance plan. I am responsible for insurance copayments at the time of my visit, and I am also responsible for any outstanding balance once my insurance claim has been processed. I authorize payment of medical benefits directly from my insurance carrier to the treating physician for services provided.

Name of Parent/Guardian:_____

Signature:_____Date:_____

Relationship_____

Patient
Name/DOB:_____

Patient
Name/DOB:_____

Patient
Name/DOB:_____

Patient
Name/DOB:_____