CHART #_____

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FINANCIAL POLICY

Thank you for choosing Janice H. Loeffler M.D., P.C. as the health care provider for your children. We are committed to the care and treatment of your children. This financial policy is an important part of your child's care. Due to increased insurance company demands we ask you to read to the following policy.

As of August 20, 2012, we have changed to **PEDSONE** for our billing services. The contact number for PEDSONE is **1-866-371-6118.**

If a patient is in for a well-baby or physical exam and is ill or a significant amount of time is spent counseling, there will be additional charges applied and subsequently a co pay may be applicable.

Please be prepared to pay for services when services are rendered and for non-covered services. If you are unable to pay your bill before services are rendered, please ask to speak to a front staff person to make arrangements. At least 50% of the office visit must be paid unless it is an illness that is an emergency/ life threatening.

1. **Self-Pay/Private Pay:** You are financially responsible for all fees due at the time of services. If paid in full at time of services, you will receive at 25% discount. VFC fees are not discounted.

2. **Insurance Cards / Insurance Plans:** Our practice participates with a variety of Commercial insurance plans. Please bring your current insurance card to each visit and this is required. It is your responsibility to know the benefits and provisions of your individual policy. If you do not provide us with the current insurance information at the time of service, we will be unable to file the insurance claim for you, making you responsible for the cost of all services. If you have questions about your insurance, please contact your insurance company member services department or your employer's Benefits Office or Resource Manager. If your insurance payment is not received within 60 (sixty) days, any remaining balance will be billed to you.
   If we are not a provider for your insurance company, in addition to co-pays and deductibles, you will be responsible for paying any non-covered charges. **We encourage you to use our Credit Card on File service**. This is a separate policy.

3. **Co-pays / Deductibles: C**ontracting with health insurance companies requires us to collect co-pays and deductibles. ***Your co-pay is due at the time of service regardless of who brings the child for the appointment.*** This arrangement is part of your contract with your insurance company. We accept cash, checks, and all major credit and debit cards.

4. **Medicaid, Peach State, Well Care, Peach Care, Amerigroup and Care Source** members are required to present at the time of each visit, a current ID Card. If you are 'inactive" you will be given the option to pay in full for the visit or reschedule your appointment. If you choose to pay for the visit, the payment will be due the day the services are rendered plus a 25% discount.

5. **Separated and Divorced Families:** For those families where parents are separated or divorced, the parent who brings the child or children to the appointment and authorizes treatment is responsible for the payment. All payments are due when services are rendered. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the responsibility of the authorizing parent to collect payment from the other parent. Janice H. Loeffler, M.D., P.C., will not act as mediator in collecting our payments. If the account is not resolved in a timely manner, the authorizing parent's information will be submitted to our collection agency.

6. **Timely Payment:** In the event that you have a balance on your account, you will receive a statement from PedsOne. The billing cycle is now on a weekly basis with letters sent at 30 and 60 days. Payment is due upon receipt. If you choose not to pay on an outstanding balance older than 90 days**,** you may be turned over to a collection agency. **We encourage you to use our credit card on file service and this information can be obtained from a front office staff.**

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7. **Collections: If you fail to make payments in full or have not arranged a payment plan, your outstanding balance over 120 days and over $100.00 will be sent to a collection agency. You will be responsible for the added fees assessed by the billing service and the collection agency. Furthermore, your child or children will be dismissed from the practice**.

8. **Returned Check Fee:** A Fee of $25.00 will be charged for each check returned to us.

9. **Missed Appointments:** If you miss two appointments without prior notification, your child or children will be dismissed from our practice.

10. **Leaving Before Being Seen:** Leaving the office after being checked-in without notifying any staff and not re-scheduling will result in a $50.00 charge. Services except for emergency care will be withheld until this is paid in full.

11. **Forms / Medical Records / Immunization Records Etc.:** If you require a form for daycare, preschool, and head start we request you bring the form with you to your child's well exam.
    A $5.00 fee will be applied at the end of your visit for all Sports Physical Forms, Camp Forms, and Head Start Forms completed during a visit.
    If you request a form to be filled out at a later date, there will be a fee charged. Please allow up to five business days for the form to be completed.
    If a request for records is made for purposes other than changing doctors, a fee will be charged.
    If records are requested again after you have left the practice and have been sent, there is a fee for this.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy and office policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

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Patient Name

_____ _____

Signature of patient or responsible party **Date**