

## GALLOWAY PEDIATRICS, LLC

Edwin Lopez-Bernard, LLC

### OFFICE AND FINANCIAL POLICY

#### I. Charges/Payments at the Time of Service

**All co-pays, deductibles, and balances are due at time of service.** Our office requires payment in full when services are rendered, unless arrangements have been made with our billing department and/or there is invalid insurance. We do not extend credit to our patients; therefore, if payment arrangements must be made, they must be suitable to both parties.

**We accept cash, checks, and all major credit cards.** It is the patient/guarantor's responsibility to know the amount of their co-pay. If the co-pay amount is not specified or is unclear, you will be responsible for 20% of the Office Visit.

#### II. Insurance Claims

**We will submit a claim for services to your insurance company for reimbursement.** You must assign benefits to our office if you do not pay for your visit in full. After **thirty (30)** days, if the insurance company has not paid your claim, the balance becomes your responsibility. We reserve the right to limited insurance submissions/inquiries.

**It is imperative that accurate PRIMARY Insurance information is given in order to properly submit claims for payment.** If insurance information provided is found to be inaccurate, the guarantor will be responsible in full for any charges incurred. Our billing office will not be responsible for any retractions from insurance companies and/or additional inquiries due to non-payment.

#### III. Billing Inquiries

**Our billing office accepts telephone inquiries between 9:00am – 4:00pm, Monday through Friday.** Every effort is made to speak with individual when they call. Please have your question and all necessary information available for prompt attention/resolution. Should we find the billing error is on our part, we will correct the problem. If, however, the problem is with the insured/insurance, (i.e. insurance termed), more information needed from subscriber, coordination of benefits, it will be the subscribers responsibility to correct the problem with their insurance company. At this time, all balances are due in full. When the insurance company issues benefits, you will receive reimbursement.

#### IV. Referrals

**If your insurance company is an HMO and requires a referral form to a specialist, we ask that you call for a referral at least 48 hours in advance.** Please do not ask our office staff to fax or mail referrals. This is your insurance company's policy. It is your responsibility to follow the rules of the insurance plan, just as we are expected to do. You are asked to call for referrals between the hours of **9:00am – 3:00pm** only. If, however, there is an emergency, and your referral falls under **GLOBAL CARE**, we will provide referral as necessary.

## **V. Monthly Statements**

**Statements are sent out each month.** This statement will include individual and or family balance with account numbers. When you receive your statement, it means the balance is now your responsibility. Our statements are clear and concise.

**Payment is expected upon receipt of the statements.** Please notify the billing office if you have questions as soon as possible so that any balances due can be taken care of in a timely manner. Please note that our office encourages payment by phone via a debit or credit card.

## **VI. Missed Appointments**

**To allow the availability of appointments to all our patients, please notify the office at least 24 hours before your scheduled time if you need to cancel an appointment.** There will be a **\$25.00** fee for an appointment that is not cancelled within the 24 hour allowance.

## **VII. Returned Checks**

**A \$25.00 fee will be charged for all returned checks.** We will not redeposit returned checks. The entire amount of check and fee must be paid in full within ten (10) days notice. If more than one return check occurs, you will be asked to **pay by cash or credit card only-no checks accepted.**

## **VIII. Record Transfer**

**In order to cover the cost of time and material there will be a fee of twenty five cents (\$0.25) per page plus postage for copying patient charts.** Charts will only be mailed direct to office practices. Parents will need to pick up chart if wanted in person and need to show picture ID. In order to ensure safe receipt we recommend that arrangements be made for requested medical record copies to be picked up. A written request is required for all record transfers. Please refer to our receptionist for any additional information and/or forms.

## **IX. Delinquent Accounts**

**An account becomes delinquent if payment is not made at time of service in reference to co-pays, and balances.** We will send a statement within the first **thirty (30) days** for payment in full. If another statement is sent, this account is now considered for collection proceedings. Our billing department does it's best to try and collect unpaid balances before collection proceedings. We extend courtesy calls, set up payment plans, work with insurance companies, etc; this requires a lot of time and effort. However, when this becomes uncollectible, we have no alternative than to turn said account over to our collection agency. Once the account is turned over to our collection agency, a percentage fee will be assessed based on the unpaid balance. Please refer all inquiries to **Rickart Collection Systems, Inc.** at **800-742-5278.** At this point, the account will be subject to discharge from our practice.

**When a patient is discharged from our practice we will provide care for thirty (30) days.** If account is resolved, patient care may be continued upon the secretion of the administrative/billing department. At that time all visits will be due at time of service and any reimbursements from Insurance Company will remain on account/or refunded.

**X. Appointments**

**Our office will treat pediatric patients, from newborn through twenty-one (21) years of age.** We cannot treat a patient **seventeen (17) years** of age and under **without** an adult present unless a written permission/power of attorney for any patient seen that is accompanied by someone other than the guarantor. We will also require identification from the person accompanying the patient. It is still the responsibility of the guarantor that all co-pays/balances be paid at time of service. Please make sure that all payments are sent with whoever accompanies the patient.

**XI. Miscellaneous Services: Forms, Letters, etc.**

**Miscellaneous services, such as drafting patient letters, often require extra time for the Physician to complete.** Due to a large volume of requests for drafted letters by the Physician, and FMLA's completion forms, there will be a minimum charge of **\$10.00** per request. Please bring any Health Inventory/School Forms at time of physical to avoid an additional charge of **\$5.00** for a later date of completion. Any other requests like: WIC forms, Immunization records, working papers will have an additional fee of **\$3.00**.

**GALLOWAY PEDIATRICS, LLC**

<b>Patient Name:</b>	<b>Patient DOB:</b>

**AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

*I authorize GALLOWAY PEDIATRICS, LLC to apply for benefits from [insurance carrier]*

*Furthermore, I authorize payment directly to GALLOWAY PEDIATRICS, LLC of the surgical and/or medical benefits, if any, otherwise payable to me for services rendered by GALLOWAY PEDIATRICS, LLC.*

**AUTHORIZATION FOR RELEASE OF INFORMATION**

*I authorize GALLOWAY PEDIATRICS, LLC, to release any medical information required by my insurance company or its designated claims processing agent in order to obtain payment of claims submitted on my behalf.*

**FINANCIAL AGREEMENT**

*I accept* full responsibility for and agree to pay to GALLOWAY PEDIATRICS, LLC any and all charges not fully covered by an insurance carrier. I understand that payment in full is due within thirty (30) days of the statement date or I must contact the billing office to make payment arrangements. I further understand that GALLOWAY PEDIATRICS, LLC reserves the right to charge interest on my outstanding balances and/or seek restitution of delinquent accounts via a third party collection agency or attorney. Any fees or court costs that are incurred during the collection process will also be any responsibility.

*I agree* to notify GALLOWAY PEDIATRICS, LLC of any changes in my billing address, telephone number and/or my insurance information. This entire authorization is valid for all episodes of care rendered by any provider associated with GALLOWAY PEDIATRICS, LLC. A copy of this authorization/agreement may be used in place of the original.

<b>Year</b>	<b>Signature</b>	<b>Date</b>
<b>2010</b>		
<b>2011</b>		
<b>2012</b>		