APC FINANCIAL POLICY

2020

Name of Patient: ____ **Date of Birth:** ____

Alice Pediatric Clinic (APC) is committed to provide you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Submit all insurance co-payments, deductibles and non-covered services on the day services are rendered. Provide your insurance company and APC with any additional information requested to complete the processing of claims filed on your behalf.
- Authorize release of information necessary for insurance filing and pre-certification (sign on this sheet below).

UNACCOMPANIED MINORS

Minor must have an authorization for medical treatment signed by his/her parent/guardian and patient's current insurance information is required. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE

By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE

Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.
Do you have current Medicaid\ Chips insurance coverage? (Please Initial Response)
□ Yes __________ □ No __________

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)

Each time you make an appointment with an APC Provider, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. **Please plan to show your current insurance card at each visit.**

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours' notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- I have read and understand that I am personally responsible for payment on this account.
- Assignment: I hereby authorize payment directly to APC or my Physician. Any changes in this authorization must be received in writing within 30 days of the effective date.
- The practice has an AFTER-HOUR fee of $50.00. After hour fee will be charged if the patient is seen after 5:00 P.M weekdays or seen on the weekend.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Parent/Guardian Signature: ______________________________________**Date:** __________________ **Date of Birth**__________

Print Name _________________ **Relationship to Patient:** ______________________ **Parent / Guardian S.S#**_______________