# Pediatric and Adolescent Care, LLP

2000 South Wheeling, Suite 300
Tulsa, OK 74104
Telephone: (918) 747-7544
Fax: (918) 747-3952
Business Office: (918) 747-7708 or billing@pac-tulsa.com

## Financial Policy

## Welcome to our Office

Thank you for choosing Pediatric and Adolescent Care, LLP, as your health care provider. We are committed to providing the best possible care and service for your children. We regard your understanding of our financial policies as an essential element of your child's care and treatment. If you have questions about your account, charges, insurance, or payments, please contact our Business Office at (918) 747-7708 between the hours of 8:30 a.m. and 5:00 p.m., Monday through Friday, to speak with a member of our business staff.

## Payment Policies

**Payment in full** is due at the time services are rendered. For your convenience, we accept cash, checks, money order, debit cards, MasterCard, Visa, Discover and American Express. If you wish to leave a standing order for credit card transactions, please notify our Business Office staff and we will provide you with the necessary forms.

**Insurance:** We will inform you if we participate with your insurance company and will handle your claims according to our agreement with them. In order to file claims with contracted insurance plans, we must have completed financial information forms and a copy of insurance card(s) for each covered member on file. After insurance has responded on charges, any outstanding balance is due at the first billing. We will file secondary insurance claims with contracted plans. If a secondary policy is in effect, please notify the office in order to set up the account appropriately. If you have secondary insurance with a non-contracted plan, please ask for a duplicate receipt of charges in order to file your claims. We do not file insurance claims for non-contracted plans except for hospital charges.

**Charges not covered by insurance:** Payment is due at the time services are rendered

**No Insurance**: Payment is required at the time of service.

**Copayments**: Copayments are to be paid upon the time of check-in.

**Divorce or Separation**: In the case of divorce or separation, the person who brings the child in for treatment is responsible for payment of services rendered. We will carry the account in the name of the person who has custody of the child.

**Returned Checks/Credit Cards**: There is a $20 service fee per item for checks or credit card transactions returned by the bank for any reason. Such items including the service fee must be paid by cash or money order within ten working days from the date returned.

**Delinquent Accounts**: If you have difficulty paying your account balance, please speak with our Business Office staff to arrange a payment plan. If your account becomes 90 days or more past due without correspondence or payment from you, your account will automatically be placed with an outside collection agency.

## More about Your Insurance

**Insurance is a contract between you and your insurance company**. We have contractual obligations with several PPO (preferred provider) and HMO (health maintenance) plans and will inform you if we participate with your insurance plan. We will file insurance claims according to our agreement with the participating insurance plan if you provide us completed financial information forms and a copy of insurance card for each covered member of the family. We must receive this information within 30 days of the initial visit. All charges will become your personal responsibility if completed insurance information is not provided or if eligibility cannot be determined. You are responsible for answering any claims inquiries sent to you by your insurance company. We will not become involved in disputes between you and your insurance company regarding eligibility, deductibles, copayments, covered charges or secondary insurance other than to supply information as necessary. For HMO plans, we must be able to verify eligibility of each

covered member for the current month. At the request of HMO plans, you will be asked to show the patient's insurance card at each visit. If eligibility cannot be established at the time services are rendered, then charges will be considered your personal responsibility.

Please be aware that there may be hospital pre-certification requirements, facility restrictions, primary care physician (PC) authorization guidelines as well as newborn enrollment procedures. Failure to comply with any of these may result in penalties to you in the form of reduced or disallowed benefits.

## Well Child Visits (Check-ups)

Many insurance plans do not pay benefits for these visits. Payment at the time of service will be required for all general checkups and immunizations unless there has been verification that benefits are payable.

An additional fee may be charged with a well visit if other problems are found and addressed by a physician. These fees MAY NOT be covered by insurance and are therefore payable by you.

## Telemedicine

We encourage our patients to seek PAC for all care and concerns of their child. We also understand the risk of exposure when bringing a child to the office. At times, a licensed nurse or provider will offer treatment options that can be completed at home. A telemedicine fee may be applied to this service.

## Urgent and/or After-Hours Visits

There may be additional fees for urgent and/or after-hours visits.

## Missed Appointments

PAC reserves the right to assess a missed appointment fee. We request 24-hour notice of cancellation; otherwise, a $50.00 fee may be applied to your account.

- I have read and agree to abide by the financial policies of Pediatric and Adolescent Care, LLP.
- In the event all or any portion of the balance due becomes past due, the person listed as responsible for payment on the account accepts responsibility for the full amount past due. In the case of separation or divorce, the person who brings the child in for treatment is responsible, unless otherwise noted.
- Payment made by check/credit card is subject to a service fee of $20.00 per item in the event the check/credit card is returned as a stop payment item.
- I hereby authorize the release of any medical or other information necessary to process claims for services provided by this practice. I also authorize payment directly to my physician of the physician's benefits otherwise payable to me but not to exceed my indebtedness to said physician. I understand I am financially responsible to the physician for charges not covered by this agreement. A copy of this assignment is as valid as the original.

**PARENT/GUARDIAN**
**TYPED NAME** _____

**SIGNATURE**_____**DATE**_____

*Our financial policy is subject to change without notice and your signature on the financial information forms presumes that you have read and understand these policies. You are encouraged to speak with our Business Office staff if you have questions or need further explanation of these policies.*