

Uptown Pediatrics Financial Policy

(Effective 2/13/23)

Patient Name(s) _____

Today's Date _____

We are committed to providing the best possible care to our patients and their families and feel that this goal is best achieved if everyone is aware of our financial policy. Changes in the health insurance industry have made the cost of healthcare challenging for both patients and healthcare providers. We've developed this policy to clarify your financial obligations and help you understand the requirements imposed by your health insurance carrier. We are happy to answer any additional questions you may have.

Payment Procedures and Payment Options:

Full payment is expected at the time of service, regardless of who brings the child to the office. This includes applicable co-payments as required by your insurance plan. We accept cash, personal checks and all major credit cards. A receipt will be provided to you for all payment transactions. As an added convenience, payment can be made online at www.UptownPediatrics.com. Contractual obligations with your insurance plan require us to collect your co-payment in full at the time of service. The accompanying parent or other adult is responsible for payment at the time of service and for providing the proper insurance identification. If there should be a dispute about the financial responsibility, we will hold the accompanying parent responsible for payment. We request that a credit card be kept on file for all payments due, including co-pays. This helps speed your check-in/out process and eliminates the need for you to receive a bill from us. _____

Insurance Coverage

As a courtesy, we will bill most insurance carriers directly. If the insurance information is not provided in a timely manner and the office is unable to bill the charges within the time limits set by your insurance carrier, the balance will become your responsibility. Co-pays must be paid in full at the time of the visit. Legally, we cannot reduce or waive co-payments, deductibles or other cost-sharing balances charged by your insurance plan. If you have an HMO plan, please assign one of the physicians in our practice as your child's primary care physician (PCP) PRIOR to your visit. If we cannot confirm that one of our providers is listed as the PCP we will ask that the appointment be rescheduled. **As insurance plan benefits vary, it is the policyholder/parent's responsibility to know the specific benefits of their plan.** If your carrier requests other information from you such as evidence of other insurance, they will not reimburse us until you provide it. If you fail to do so, you will be billed for any outstanding charges. Billing insurance does not guarantee payment and the ultimate responsibility of the account will be yours. _____

Change of Insurance/Change of Account Information

Please notify the office as soon as possible of any and all account changes, including co-pay amounts, insurance updates, and change of mailing address. If the account holder does not notify the office within 15 calendar days of these changes, the assigned account holder becomes responsible for any and all charges. _____

Out of Network/ Self-Pay

If we DO NOT participate with your insurance or you DO NOT have proof of insurance at the time of check in, you will be considered a self-pay patient. Full payment will be required at time of service. _____

Newborn Enrollment

It is essential that you contact your insurance plan or the policy holder's Human Resources department to enroll your newborn on your policy. We recommend doing this within the first few days of your baby being born as it

often takes a few weeks for the baby to show up on the plan as a covered member. Most health plans allow 30 days to add your newborn, otherwise you may have to wait until an open enrollment period to add the child. Delaying enrollment may result in us having to bill you directly. _____

Non-covered Services

We will always provide your child with what we consider the best and most-up to date medical care. Some insurance plans limit coverage of procedures and services in order to control their costs. As a result, certain services we provide for your child may not be reimbursed by your plan and you will be responsible for these charges. These may include (but are not limited to) charges for after hours, weekend or emergency visits, telemedicine and telehealth visits, allergy testing, and recommended preventive screening. _____

Additional Fees

Prenatal Meet & Greet

There is a \$50.00 fee per doctor for a prenatal, meet and greet visit. If you choose to stay with Uptown Pediatrics after your baby is born, this fee is credited back to your account with us. _____

Laboratory services

We will send your lab work to the appropriate laboratory based on the insurance information you have provided to our office. We are not liable for insurance billing and balances due from outside labs. _____

After hours

There is an additional \$75.00 fee charged for visits occurring on weekends, holidays and after routine office hours. We will bill this charge to the participating insurance plan, but you may be responsible if your insurance carrier does not cover this charge. _____

Emergency Basis

For services provided on an emergency basis for patients **without an appointment**, there is an additional \$60.00 fee. We will bill this charge to the participating insurance plan. You may be responsible if your insurance carrier does not cover this charge. _____

Telemedicine and Telehealth Visits

There are additional fees for video, telephone, email and portal correspondence with physicians. We will bill this charge to your participating insurance provider, but you may be responsible for a portion of this visit if your insurance carrier does not cover the charge. _____

Medical Records

With the signed request from the patient, parent or legal guardian, we will provide you with a copy of your child's medical record. There is a charge of \$1.00 per page for this service. If you request that we mail these records, additional postage fees are attached for mailing. We only mail records via a mail method that requires a signature and proof of delivery upon receipt. _____

Camp/School Forms: There is a one-time annual fee of \$25.00 per child for unlimited camp/school forms completed. Forms will be returned via patient portal unless you provide a self-addressed stamped envelope along with your form. For expedited forms (24 hour turnaround), there will be an additional fee of \$25 per form.

Missed Appointment Fee

Missed appointments or late cancellations represent a cost to us, you, and the other patients that could have been seen during the time set aside for your child. A \$75 "no-show" fee will be charged for appointments not canceled within 24 hours of the scheduled appointment. Please call ahead if you are unable to keep an appointment and we will be happy to reschedule you. _____

Returned Check

There is a \$25.00 fee for any check returned to us from the bank. _____

Collection Agency

Any charges remaining unpaid for more than 90 days from the date of service are considered delinquent and may be sent to a collection agency. In this situation, the responsible party will have to correspond with the collection agency regarding any financial arrangements and will be responsible for the original amount due in addition to any fees charged for the cost of collection. _____

Payment Plans

Uptown Pediatrics understands that full payment may not be possible in certain circumstances. As a courtesy, we may offer the assigned account holder a payment plan. Payment plans are approved on a case-by-case basis and may be discussed with our Billing Department. Families with a payment plan must be in full compliance with all of the conditions of the agreement at the time of visit. Failure to make the scheduled payment, or not paying the balance in full, may result in your account being turned over to a collection agency. _____

Should you experience financial hardship, please contact our Billing Department for assistance with a payment plan. They are available Monday through Friday between 8:30am and 5:00pm.

I have read the above policy and agree to its terms; by signing this financial policy, I acknowledge that all bills will be sent to me and that I am financially responsible for all bills:

Signature of Responsible Bill Payer

Print Name

Relationship to Patient