FINANCIAL POLICIES AND PROCEDURES

At Maeville Pediatrics, we believe that all patients who are rendered care at this office deserve the best medical care that can be provided. For us to provide you with the highest quality medical care and current technology, we must ensure that we are able to meet the expenses necessary to operate this facility. To ensure that these expenses are met, we provide you with this Agreement regarding our financial policy and your agreement to pay for services provided. Please sign and date this Agreement on the last page to indicate you accept these terms.

PAYMENT AT TIME OF SERVICE, FEES AND COLLECTIONS

Your insurance policy is a contract between you and your insurance company. We will not become involved in disputes between you and your insurance carrier. We do provide your insurance carrier with information regarding your diagnosis and treatment. We do not get involved in such matters as disputes regarding deductibles, copayments, non-covered charges and "usual and customary" charges. If your insurance carrier does not provide payment within 40-60 days after treatment, you will be responsible for payment. You are responsible for timely payment on your account. We require that you pay any amount not covered by your insurance such as deductibles and copayments under your policy on the day of service. If your plan requires you to pay co-insurance, you will be required to pay that. Maeville Pediatrics is required, in accordance with its contract with your insurer, to collect from you deductibles and copayments. We will determine your copay and how much of your yearly deductible under your policy has been met for the year. If you are unable to pay your copayment at check-in, another appointment will be made for you. Any additional payment owed will be collected in full at the time of service. If needed, we will work with you to arrange a payment plan.

We will request to see your current insurance card and photo identification at every visit so that we may bill the insurance company in a timely fashion. It is your responsibility to ensure we receive current and valid insurance coverage at each visit. It will be reviewed or copied every time you are here for a visit. If a claim is rejected because your insurance does not cover the type of service rendered, you will be held responsible for the outstanding balance. **Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, whether a referral or prior authorization is required, and what your copay is and what your deductible is.** It is your responsibility to understand your insurance coverage. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered. Please educate yourself as to your coverage so that office visits, procedures, testing, and specialist referrals may be arranged to best suit your needs.

Once we determine your personal financial obligation or after your insurance company reimburses Maeville Pediatrics, for a portion of your care, we will automatically charge your credit or debit card you are required to maintain on file with our office. Any account past due by 30 days or more may be subject to submission to our collection agency. If your account becomes delinquent and is placed into our collection process, collection and/or court and attorney's fees will be your responsibility and added to your balance. Maeville Pediatrics reserves the right to discharge any patient at this point. By signing our financial policy, you agree to pay these added fees, along with all costs associated with the collection of your account, including interest charges.

If a new problem is encountered, or if changes in treatment of a pre-existing condition are discussed in the process of performing a visit or exam, an additional copay and deductible payment may be incurred.

If you are seen in our office by a nurse or a medical assistant for minor medical services you may be charged a limited office visit, and applicable co-pays will be collected.

If you carry a balance on your account during the time you present at our office, a payment on your account will be required at the time unless a Credit Card is kept on file or a payment plan is in place. Maeville Pediatrics reserves the right to terminate any patient who misses a payment.

COPAYS AND DEDUCTIBLES

Copays and deductibles may be required by your insurance and plan. This is a contract between you and your insurance. We also have contracts with your insurance, and we are required to collect these at each visit. We will not waive any copay or deductible. If you are unable to pay your copayment at check-in, we may ask you to reschedule your appointment. Any additional payment owed will be collected in full at the time of service. We understand every family situation is different and if needed, we will work with you to arrange a payment plan. Please ensure that if you are unable to bring your child in yourself, whoever brings the child in is prepared to make all payments.

CREDIT/DEBIT CARD ON FILE

Maeville Pediatrics is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. Your card will only be charged the outstanding amount that your insurance company determines to be patient responsibility, as detailed in your Explanation of Benefits (EOB). Once your card is charged, a receipt will be sent to you by email. Statements are wasteful of paper, stamps, and envelopes and
are not efficient. We need to ensure that we have a guarantee of payment on file in our office.

You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits, or EOB. This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance to pay. We receive the same letter that you do. It arrives about 20 – 30 days after your appointment. We look at each Explanation of Benefits (EOB) carefully and determine what your insurance has determined as patient responsibility. We do not store your sensitive credit card information in our office. We store it in a secure fashion with a reputable financial firm called a gateway. We access your information only on this site to process a payment. You will be required to sign a credit card on file authorization statement that will allow us to charge an amount agreeable to each of us until your balance is paid in full. We will always work with you to understand if there has been a mistake, and we will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us and the amount that you have agreed to, in the same way that we normally determine how much to send you a bill for in the mail.

PAYMENT OPTIONS

Our office accepts most credit and debit cards. Our office also accepts valid check or cash. There will be a $50 fee for all returned checks. Once we have a returned check for you, we may require that all future payments be with cash, money order, cashier's check or credit card. Anytime a co-pay, deductible or balance is due, we will charge the fee to your credit card which will help to keep you at a zero balance and paid up in full with your credit card on file.

CASH PAYMENT
If you wish to pay cash, you will always be provided with a receipt so that you will have a record of your payment. Please make us aware if you are not provided a receipt.

NON-CONTRACTED INSURANCE (Out of Network)
If you have an insurance plan that we do not participate with, you may or may not have out-of-network benefits. These benefits typically have a higher copay, coinsurance, and/or deductible out of pocket cost. You will be considered a self-pay, uninsured patient if you do NOT have out of network benefits and if your insurance does not pay for the service, you are financially responsible. Please understand that what your non-contracted insurance deems "allowable" may not cover the entire charge and you would be responsible for any difference.

UNINSURED/SELF-PAY
We are happy to work with families that prefer to pay directly for services or do not have insurance.
We offer a discount to all self-pay patients who pay in full at time of service. Payment is expected at each visit. We require a $100 non-refundable deposit to be placed with us to schedule your first visit with us which will then be used toward the total cost of your first visit. If you fail to show up for your visit, you will be charged our 'no-show' rate.

MISSED APPOINTMENTS/NO SHOWS/LATE FOR APPOINTMENT
We understand that you may not be able to keep all your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you $100.00 for any no-show if permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. [Name of Practice], reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

Missed appointments have a detrimental impact on our practice and other patients. We understand that you may not be able to keep all your scheduled appointments or might occasionally be late, so if you must cancel or re-schedule your appointment, please do so at least 24 hours in advance. We reserve the right to charge $25 for regular appointments cancelled without advance notice of at least 1 business day. Appointments that are scheduled for the same day and then cancelled, as well as no-shows for an appointment, may be assessed a $50 charge. (This policy does not apply to patients with Medicaid and Medicaid HMO insurance.) After three no-shows or same-day cancellations, your family may be dismissed from the practice. Payment of the missed appointment will be required prior to scheduling another appointment.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late for an appointment, Maeville Pediatrics may reschedule your appointment.

FORMS AND MEDICAL RECORDS FEES
Due to the increasing costs of providing our patients with the highest standards of care, we must impose a charge for certain records and forms. It takes time for our providers and staff to retrieve and copy files, complete forms and write letters. The following charges apply:

FMLA, Disability, Corps, School forms not completed during an appointment, and Supplemental insurance forms $15.00.

Dictated letters, extensive forms with review of medical records $15.00 per page

DIVORCED/SEPARATED PARENTS AND CUSTODIAL ARRANGEMENTS

Maeville Pediatrics does not get involved in disputes between divorced, separated or custodial parenting arrangements regarding financial responsibility for their child's medical expenses. 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, custodial or other arrangement places that obligation on your former spouse or the child's other parent. We will be happy to provide receipts for paid medical bills for you as requested.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Maeville Pediatrics: (1) release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Maeville Pediatrics. This order will remain in effect until revoked by me in writing.

I have received the practice's Medical Authorization for Release / Disclosure of Protected Health Information / HIPAA Privacy Notice.

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE

I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits.

In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit

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evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it were the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

_________________________________ _______________________

Signature Date

Patient Name (PRINT):

_________________________________ _______________________

Signature Date

Name of Person Financially
Responsible for Patient's
Treatment (PRINT):

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