FINANCIAL POLICY

We would like to thank you for choosing ***Child & Teen Wellness Center*** for your child's medical care. Maintaining positive communication between our providers and our patients is a crucial factor in our ability to successfully provide high quality care to your family. To help in achieving that goal, we would like to make you aware of the following policies. These policies protect our ability to provide care and to responsibly adhere to mandated guidelines established by contracted insurance carriers. If you have any questions, please don't hesitate to ask a member of our staff.

If you have questions about insurance related issues, our billing department is available between the hours of 10:00 a.m. and 5:00 p.m., Monday through Friday at 425-615-6496 ext. 104.

PLEASE BRING THE FOLLOWING WITH YOU TO EVERY VISIT:

- Current insurance card(s)
- Your co-pay, co-insurance and/or deductible
- Photo identification

INSURANCE:

Please bring your current insurance card to every appointment so we can verify insurance coverage.
If we don't have your current insurance information or your coverage can't be verified, you may be considered a self-pay patient (See *Self-Pay* policy below).
If we participate with your insurance (in-network/participating):

- We will submit all eligible charges to your insurance company for reimbursement.
- Co-pays, co-insurance and deductibles are the patient's responsibility and are due at the time of service in accordance with your insurance carrier's agreement and our office policy.
- We accept payment by *cash, check or credit card.*
- If you are unable to pay the co-pay, co-insurance, deductible or balance at the time of service, a charge of $20.00 fee may be added to the patient account.

If we *DO NOT* participate with your insurance company (out-of-network/non-participating):

- Payment is required at the time service is provided.
- We are happy to provide you with an itemized receipt to submit to your insurance company for reimbursement.

SELF-PAY PATIENTS:

We understand that there may be a time that your health insurance policy may lapse. If this is the case, you will be considered a "Self- Pay" patient.

- Payment is required at the time of service.
- A discount is given to all self-pay patients.

RETURNED CHECK FEE:

A fee of $38.00 is charged for all retuned checks. The $38.00 fee and the outstanding balance must be paid within 30 days.

Initial _____

PATIENT BALANCES:

- Patient statements are mailed on a regular basis. Payment is expected within 30 days of receipt of the statement. For your convenience, payment can be made in the office, by mail, by phone, or on-line.
- If you have questions about your statement, our billing department is happy to assist you. To reach our billing department directly, please call 425-615-6496 ext. 104.
- Please notify the Practice of any changes of information, such as a change of address, email, phone number, etc.
- If you're having trouble paying your bill, please discuss the situation with us. Arrangements for payment and initiation of a Payment Plan can almost always be made.
- If no payment has been received on a patient/family's account for a period of 90 days, or a Payment Plan has not been initiated or adhered to, your account may be sent to our collection agency.

CANCELLATION & MISSED APPOINTMENT POLICY:

- We understand that there may be situations when you need to cancel your child's appointment. Appointments must be cancelled with a minimum of 24 hours' prior notice. Appointments which are cancelled without at least 24 hours' prior notice may be subject to a $40.00 fee ($60.00 for a cancelled consultation appointment). This fee is not billed to your insurance carrier.
- If a patient misses an appointment without contacting our office ("No-Show, No-Call."), a fee of $40.00 ($60.00 for a missed consultation appointment) will be charged. This fee is not billed to your insurance carrier.
- Emergencies do come up. If you have an emergency and can't keep or have missed your child's appointment, please let us know as soon as possible.

FORM FEE CHARGES: (patient must have a current well exam on file)

We are happy to assist you with the completion of your form(s). *Patient must have a current (within the past 12 months) well exam.* There is a nominal charge for this service. ***The fee schedule (per form) is as follows:***

- School/Camp/Day Care/ Sports Physical forms: $10
- Immunization forms only: $5
- Express (48 hours) forms: $25
- FMLA forms (require an appointment): Fee is included with the office visit
- Medication Forms: No Charge

AFTER HOURS TELEPHONE CALLS:

We are available for your urgent issues 24 hours a day, 7 days a week. If you have a non-urgent matter, we ask that you call during normal business hours. *Non-urgent* telephone calls received after normal business hours are subject to a $25.00 fee. Non-urgent calls include, but are not limited to prescription refill requests, long-standing problems, and referral requests.

The After-Hours fee encompasses calls received:

- Weekdays after 5:00 p.m.
- Sundays after 10:30 a.m.
- Saturdays (Office Closed) and holidays all day

MEDICAL RECORDS COPYING FEES:

ALL RECORD REQUESTS MUST BE SUBMITED IN WRITING.

- Copying fees include 76 cents per page and the cost of postage and handling. We also offer the option of a digital (CD) copy of the health record for a $15 fee, plus postage and handling.
- An additional preparation fee of $22.88 is required if medical records are being sent to a third party, such as an attorney or a second opinion physician.
- Completion of these requests may take up to 28 business days.

Initial _____

AGREEMENT OF FINANCIAL RESPONSIBILITY

I have received, read, and understand the Child & Teen Wellness Center Financial Policies.

1. Patient name: _____ Date of Birth: _____
2. Patient name: _____ Date of Birth: _____
3. Patient name: _____ Date of Birth: _____
4. Patient name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____

Assignment of Benefits

I authorize Daniel J. Levy, MD, PA/Child & Teen Wellness Center and their health care providers/clinicians to submit claims on my behalf to my insurer for services rendered. I request and authorize payment from my insurer to be made directly to Daniel J. Levy, MD/Child & Teen Wellness Center. I acknowledge that the information I have reported is correct. I authorize the release of any information necessary for claims to be filed to my insurance company, to include health information. A copy of this authorization may be used in place of the original.

Parent/Guardian Name: _____

Parent/Guardian Signature: _____ **Date:** _____