pediatric associates
OF THE NORTHWEST

Billing & Financial Policy

Welcome to the PANW Family! Our goal is to provide high quality pediatric care in our community. To better serve our patients, the following is our billing and financial policy. We are committed to providing you with exceptional care. To accomplish this, we are requesting your help in notifying our offices of any patient information changes to avoid unnecessary billing issues. For patient balances, we have many options for you to pay your bill: cash, check, Visa/MasterCard/American Express, and payment plans. Please call our Billing Department at (503) 419-4923 to make a payment or set up a payment plan.

Payments: As a courtesy, we will bill most insurance carriers directly. Insurance card(s) are required at each visit. If your insurance has a **co-payment** for the visit, it is also required at the time of the visit. Billing insurance does not guarantee payment. Any unpaid balance is your responsibility. If the patient's insurance information is not provided in a timely manner and the clinic cannot bill the charges within the time limits set by your insurance carrier, the balance will become your responsibility. If you have an HMO plan, please assign one of the physicians in our practice as your child's primary care physician (PCP) with the insurance carrier, 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. ______ (initials)

Change of Insurance or of Account Information: Please notify the office as soon as possible of 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 all outstanding charges. ______ (initials)

Newborns: Please contact your insurance as soon as possible after the birth of your child. 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. We will hold all charges for the child for the first 30 days until we can verify eligibility. If, after 30 days, we are unable to verify the child has been added to the policy, the balance will become your responsibility. ______ (initials)

Out of Network: 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 out of network and therefore become a self-pay account. _____ (initials)

Vaccines: If the patient is aged 18 years or younger with no insurance, the Oregon Vaccines for Children program (VFC) will cover the cost of vaccines but NOT the current administration fee per vaccine. _______ (initials)

Self-Pay Accounts: If you do not have insurance or have a policy we are not contracted with, please come prepared to pay for your visit in full upon check-out. We offer a 25% discount (except for vaccines/supplies) to all self-pay accounts. For all preventative visits, we require a $100 deposit at the time of the visit with any remaining balance being billed to you. If you are unable to make the $100.00 deposit at the time of service, we will request that you set up a monthly payment plan before the visit. ______ (initials)

Missed Appointment: Missed appointments or late cancellations represent a cost to us, you, and the other patients who could have been seen during the time set aside for your child. Notification of appointment cancellations is required by 8 am on the day of the scheduled appointment, if you are unable to keep your appointment time. Any missed appointment or late cancellation will incur a "no show" fee of $25.00 for medical appointments or $100.00 for behavioral health appointments. Families may be asked to pay the "no show" outstanding balance prior to being seen for the next appointment. If a family has ongoing missed appointments without contacting the clinic, the family may be dismissed from the practice. ______ (initials)

Preventive vs. Office Visits: When children are scheduled for preventive care (well child checkup), it is YOUR responsibility to verify your insurance benefits before the appointment. If your child is sick on the day of the well child visit, we can either see your child for the sick visit and reschedule the well check or see the child for

both during in the same time frame. *Insurance may not cover both visits on the same day, and you may be subject to a copay or deductible for the sick portion of the visit*. If your insurance does not cover this, it will become your responsibility for payment. _____ (initials)

After Hours/ Holiday Care: There is a $42.00 fee for medical visits that occur after 5:00 pm, daily, on weekend days and federal holidays. If that fee is not covered by your insurance carrier, the assigned account holder is financially responsible for this charge. _____ (initials)

Circumcisions: The cost of a circumcision is $450. PANW asks that you either make payment in full before the procedure, or place a credit card on file to pay any balance remaining on the account after insurance has been processed. _____ (initials)

Care Management: Some patients have ongoing health conditions and may benefit from assistance from our Care Management team. This team helps caregivers manage ongoing health conditions by periodically checking in regarding your child and family's health care needs and treatment goals, helping to schedule appointments for preventative care, and collaborating with you to understand the care needed for your child(ren)'s health condition(s). Care Management will act as a liaison between you, your PCP and other members of your PANW team working in conjunction to create a plan that provides the best care for your child(ren)'s health at home and in the community. These services will be billed through your insurance carrier and fees may not be covered. Any portions not paid for by the insurance carrier will be your responsibility. ______ (initials)

Outstanding Balances: If you have a personal balance on your account, a monthly statement will be sent. Unless authorized in writing, payment is due upon receipt of the statement or within 30 calendar days. (initials)

Credit Card On File: To ensure swift processing of owed balances, PANW offers each patient the option to put a credit card on file. This card can be used for outstanding balances (balances owed after insurance has been processed), or for copayments. Your card information is kept secure. Credit Cards kept on file will be charged only when your account balance remains outstanding on the 30th day of the next month following your visit. ______ (initials)

Payment Plans: Pediatric Associates of the Northwest understands that full payment may not be possible in all 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 management team. Families with a payment plan must be in full compliance with the agreement's conditions at the time of the 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. ______ (initials)

Returned Checks: A $35.00 fee will be charged for any checks returned for insufficient funds and you will be asked to pay by cash or with credit card for future visits. ______ (initials)

Collections: Delinquent accounts are balances not settled within 90 days of the original statement. In the unfortunate event that we need to assign an account to a collection agency, we will be adding an additional fee of $150 .00 to the delinquent balance. Any discounts will be added back to the balance and the full amount will be given over to the collection agency. The second time a family is assigned to a collection agency, the family will be required to pay all collection balances in full before being able to be seen at PANW again. ______ (initials)

Review and consent of this policy is required prior to services rendered

Patient's first name: __________________ Last name: __________________ Birthdate: ____/____/__

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Patient's first name: ___________________ Last name: ___________________ Birthdate: ____/____/__

My initials above and signature below certifies that I have read and consent to the outlined policies and procedures. I assign Pediatric Associates of the Northwest all payments to which I am entitled for medical and surgical expenses. I understand that I am financially responsible for all charges whether covered by insurance or not. I understand insurance copays are due at the time of service.

______________________________ ______________________________ Date: ____/____/__

Signature of parent/guardian **Printed name of parent/guardian**