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 25 hours in advance of the appointment, if you are unable to keep your appointment time. Any missed appointment or late cancellation will incur a "no show" fee of $50.00 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 more than 3 ongoing missed or late canceled appointments in a 12 month period they 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)

Circumcision: The cost of a circumcision is $450. PANW asks that your 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: PANW 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. T he 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: ___/___/_____

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**

Credit Card on File Policy for Families

Pediatric Associates of the Northwest requests that a valid credit card be kept on file, except for patients with Medicaid insurance.
This policy is designed to:

- Help you avoid billing related fees
- Streamline the office billing process
- Most importantly, focus our time and energy on your children and their medical care

The card information is stored electronically in an encrypted form and **cannot be viewed by our office staff. All paper forms will be shredded once scanned.** Your signature will authorize the card to be used **only** when your balance becomes past due.

How the policy works:

1. At the time of registration or check-in, you will be asked for your credit card information to be electronically stored in encrypted form in our computer. Only the last four digits are visible to our staff.

2. As before, we will bill your insurance carrier as a courtesy for all charges related to the visit.

3. When we receive an explanation of benefits (EOB) from your insurance, we will send you a statement the following month via text or mail. If we have not received payment by the 30th of the same month, we will charge the credit card on file for the balance due (on statement).

4. If **Pediatric Associates of the NW** attempts to use your card and it is declined or has expired, **Pediatric Associates of the NW** will send you a new statement with a note attached asking for current credit card information.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. If you feel that we have charged your card in error, please contact our billing office. If a mistake has been made, we will reverse the charges.

You can contact our billing department by calling: (503) 419-4923

CREDIT CARD ON FILE

PANW OFFICE USE
Billing Acct #:

Billing Acct Name:

Today's Date:

By completing this form, you are enrolling into the Credit Card on File program.

Until further notice I, _____ hereby authorize Pediatric Associates of the Northwest to charge the patient-responsible balances on my account* to the following credit card.

*Account refers to the financially responsible party as indicated in PANW's health record system, which may include multiple patients, such as siblings seen at the clinic.
Note: Once submitted, your credit card information will be securely stored and not accessible by our staff.
By signing below, I authorize Pediatric Associates to process payments to my credit card using the card information below.

Cardholder Signature Date

Last4:

Cardholder Name (as it appears

Address: City, State, Zip

Email Address: Phone #:

Card Number (Last 4 digits only): Expiration Date:

Security Code:

Card type: ☐ Visa ☐ Mastercard ☐ American Express ☐ Discover

PANW OFFICE USE ONLY:
ACCOUNT NUMBER: _____ AUTHORIZATION/SIGNATURE DATE: _____
SCANNED AUTHORIZATION SIGNATURE TO CHART (NOT CC INFO) BY:_____ PCC UPDATE: CCOF