

# Lexington Pediatrics, P.C.

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Pediatric and Adolescent Medicine

## **FINANCIAL POLICY**

We would like to thank you for choosing Lexington Pediatrics and allowing us to provide your healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients at the least cost.

We are committed to providing you with the best possible care. In order to accomplish this, we need your assistance in reading and understanding financial responsibility and our payment policy.

### **RESPONSIBILITY FOR THE BILL**

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While the practice will file verified insurance for payment of the bill(s) as a courtesy to the patient, the patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of the practice in effect at the present time.

### **ACCEPTANCE OF INSURANCE**

We cannot bill your insurance company unless you give us your insurance information (copy of card). Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

If you do not have insurance that we participate with, **FULL PAYMENT IS EXPECTED AT TIME OF SERVICE**. We will give you a receipt to submit to your insurance company for reimbursement. You are responsible for your bill regardless of the status of an insurance claim.

Our office cannot always tell you in advance whether or not your charges will be covered by your insurance plan. Each insurance company has multiple plans that vary with employer group contracts. We ask that you be familiar as possible with your own plan, including types of coverage and restrictions on x-ray, laboratories, and emergency rooms. While our staff is trained to assist you with your insurance questions, **COVERAGE ISSUES** can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

## POINT OF SERVICE COLLECTIONS

Payment for service is due at the time the service(s) is rendered and non-emergency services may be deferred until the necessary payment arrangements have been accomplished.

Payment will be accepted in cash, checks, MasterCard, Visa or American Express.

Patients unable to comply with the Point-of-Service payment policy will be referred to our billing department for necessary arrangements.

## PAYMENT ARRANGEMENTS

The practice will make a reasonable effort to assist patients/guarantors in meeting their financial obligations. Financial arrangements for payments will be made at the practice's discretion, based on the amount.

## PATIENT RESPONSIBILITY

Balances after insurance are due within 30 days of the insurance payment, unless other satisfactory arrangements have been made with the practice.

Not all services are covered by all insurance companies. It should be understood that by accepting the service(s), the patient/guarantor is responsible for payment regardless of whether the insurance covers the service.

The practice cannot become involved with any third party liability matters and must always look to the patient/guarantor for payment of the bill.

According to your insurance contract, you are obligated to pay any co-pay due at the time of service.

## COORDINATION OF BENEFITS

We will submit any non-covered services and/or deductibles to your secondary insurance, provided we are contracted with the payer. Primary insurance copayments are expected and due at the time of service. Co-pays **will not** be balance billed to any secondary insurance.

## WORKERS' COMPENSATION CLAIMS

Workers' compensation claims must be authorized by your employer. At the time of your appointment, be prepared to provide:

- Workers' compensation claim number
- Date of injury
- Necessary claim forms
- Name, address and telephone number of employer, immediate supervisor, and workers' compensation insurance carrier

If a workers' compensation carrier denies a claim, you will be responsible for charges incurred as a result of the claim. If you have any questions, please speak with our billing manager.

## MINOR PATIENTS

The adult accompanying a minor and the parents (or guardians) are responsible for full payment at time of service. We are not party to any legal agreement between divorced or separated parents.

## OUTSTANDING BILLS

The practice reserves the right to request deposits or payment in full for any outstanding balances. Deposits will be based on the outstanding balance plus the patient's share of the bill for the new service(s) to be performed.

## RETURNED CHECKS

Any payment made by check that does not clear your bank account will result in a fee for insufficient funds. Our fee for insufficient funds is \$25 and will be added to your account for each returned check.

## BAD DEBTS/LEGAL ACTION

If your account is not paid in full or satisfactory arrangements made within the allowable time frames, the practice reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance. In the event that your account is turned over for collection, in addition to the principal balance owed, you will be responsible for all legal, attorney, and collection agency fees.

PATIENT RECORDS, CORRESPONDENCE AND FORMS COMPLETION

Copies of pertinent medical records are available to the patient or and authorized representative for a nominal fee, after we receive a signed release. Please allow ten (10) working days notice. Special documentation requests other than insurance company requirements, such as letters and forms completion, will incur a fee. Please speak with our staff for details.

RELEASE OF INFORMATION

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

If unusual circumstances make it impossible for you to meet the terms of this financial policy, please discuss your account with our business office. This will avoid misunderstandings and enable you to keep your account in good standing.

I have read and understand the above policies, and I agree to accept responsibility for any financial obligations incurred.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name