Rainbow Pediatrics

Office Financial Policy

Parents are required to pay for their child's health care at the time services are provided. Upon request, we will be happy to provide you with an estimate of the cost for specific services before your appointment. We accept cash, checks, MasterCard and Visa credit and debit cards. For your convenience, we also offer the option of keeping a credit card on file.

It is your responsibility to bring your most current insurance card with you to every office visit. You will be asked to present the card upon arrival along with any applicable co-payment. If you have changed insurance since the previous visit, please obtain the expiration date of the old policy and the effective date for the new coverage prior to your appointment. If this information is not provided, you will be expected to pay at the time of service.

Managed Care Policyholders: Co-payment and deductible are payable in full at the time of service. If you do not have an active/ valid insurance card, payment is expected at the time of service. Please check with your plan to verify that we are a participating provider. Any services received and later denied by your insurance carrier are your responsibility.

Referrals: Some insurance companies require a referral if your child needs to see a specialist for any reason. It is your responsibility to call your insurance company to determine if a referral is needed. If a referral is required, please let us know and we will arrange it for you. Referrals ***MUST*** be completed at least 36 hours in advance. Any referrals required with less than 24 hours notice will be subject to an additional fee.

Lab/X-ray Procedures: Often we need to order lab or x-rays and other procedures. We use Nationwide Children's Hospital as our lab/x-ray facility. If your insurance policy does not include Nationwide Children's Hospital as a preferred provider, please obtain the name of the alternative facility and inform the physician in advance. If we do not obtain the alternative facility information and lab/x-ray procedures are not covered, we cannot be responsible for payment.

Billing: Account balances not paid after 2 statements have been sent will be forwarded to our collection agency and a collection preparation fee of $15.00 will be charged to the account.

No Show Policy: A "no-show" charge of $50.00 will be billed when there is a failure to provide a 24 hour cancellation notice or failure to arrive for a same day scheduled appointment. This charge is not covered by insurance and you will be responsible for payment. Every attempt is made to provide reminder calls for appointments scheduled in advance; this is a courtesy only and has no effect on fees for missed appointments.

Copay Policy: Per the contract you have with your insurance company, copays must be made at the time of service. If copayment is not made and treatment is rendered, a $15.00 charge will be added. This charge is not billable to your insurance company and will be your responsibility.

Covered/Non-Covered Services: **Rainbow Pediatrics is not responsible for knowing your insurance policy coverage. You must contact your insurance company to determine what your policy will cover.** I understand the billing staff of Rainbow Pediatrics will file all claims for covered services with my insurance company if the physician is a contracted provider. I understand I am responsible for any balances that may be due to the physician as a result of:

- co-insurance or co-payments
- annual deductible amounts
- non-covered services
- out-of-network charges
- terminated coverage
- exhausted benefits
- no insurance coverage
- failure to respond to insurance company correspondence or inquiries
- failure to list our physician as your primary care physician
- failure to notify in advance that Children's Hospital lab/x-ray facility is not a preferred provider

Release of Information and Payment Authorization:

All Insurance Companies and Third Party Payers: I hereby authorize Rainbow Pediatrics and/or any of its representatives to submit a claim to my Insurance Carrier or its intermediaries for all services rendered by the physician(s) and authorize my insurance carrier or its intermediaries to issue payment directly to Rainbow Pediatrics and/or physician(s) rendering service. I authorize the release of any and all medical information to my insurance carrier or its intermediaries regarding services rendered.

Medicare and Medicaid: I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of Medical or other information about me release to the Social Security Administration, Medicare, Medicaid, or its intermediaries or carriers, any and all information needed for this or a related Medicare or Medicaid claim. I authorize and request that payment be made directly to Rainbow Pediatrics.

Guarantee of Payment: I understand that filing claim with my insurance company or other third party payer, under any circumstances, does not relieve me from my responsibility for the payment of all charges, I further acknowledge that I am responsible for the payment of all charges for services rendered by Rainbow Pediatrics to me or the patient indicated. By signing this document I personally guarantee the payment of these charges for medical services rendered. This includes, but is not limited to claims filed for Workman's Compensation and/or claims due to personal injury accidents/illnesses. I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date. I understand that I will receive a statement for any balance due after the claim has been processed by the insurance company. I understand and agree that the balance on my statement will be paid in full to the physician within 30 days. If the balance is not paid within 30 days, I understand that a late fee of $25.00 per month will be added and I may be turned away for non-emergent services until the balance is paid.

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 years of age **Date**

Rainbow Pediatrics

We ask that you realize that we don't work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

Advanced **B**eneficiary **N**otice

The following is a list of services that will *NOT* be billed to your insurance carrier. The fact that your insurance carrier does not cover a particular service does not mean you should not receive that service.

Service	
Complex Telephone Consultation	$50.00
Call placed to After Hours (10pm-7am)	$25.00
Standard Form Fee (unless completed during the preventative visit)	$10.00 per page
Complex Form Fee (unless completed during an office visit)	$40.00
Complex Pre-Authorizations	$50.00
Travel Consultation via Visit or Telephone	$75.00
Synagis Co-ordination/Authorization	$50.00
Emergency Referral	$50.00
Complex Medical Management	$75.00 annually

Parent/guardian will also be financially responsible for any/all services performed and denied by your insurance carrier. It is your responsibility to verify any/all services with your insurance carrier.

Signature of Understanding: I have read and understand that I will be held financially responsible for the above mentioned service, as well as any other services performed by Rainbow Pediatrics and denied by my insurance carrier. I agree to provide Rainbow Pediatrics the most current insurance card at every visit.

X_____ _____

Signature of Patient or Parent/Guardian if Patient is under 18 years of age **Date**

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Signature of Witness **Date**