FINANCIAL POLICIES

Pediatric Associates, Inc.
450 Veteran's Memorial Parkway, Building 10, East Providence, RI 02914

Office Policies

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a good flow of communication and enables us to achieve our goal. Please read each section carefully and initial. If you have any questions, do not hesitate to ask a member of our staff.

Appointments

We value the time we have set aside to see and treat your child. We do not double book appointments. If you are not able to keep an appointment, we would appreciate 24-hour notice. There is a charge of $30 for missed appointments. In most instances we call to confirm appointments. This call is a courtesy. It is your responsibility to know the time and date of your child's appointment. Lack of a reminder call will not result in the missed appointment fee being waived.

If you are more than 15 minutes late for your appointment it will be necessary to reschedule your appointment. If the schedule allows we may make exceptions to try to accommodate you. We strive to minimize any wait time for our patients. However, if emergencies do occur they will take priority over a scheduled visit. We appreciate your understanding.

Before making an annual physical appointment, check with your insurance company as to whether the visit will be covered as a healthy (well-child) visit.

We see patients by appointment only. Walk-ins are triaged by the nurses and may be offered the next available appointment if warranted.

We see sick visits on the weekend on an as needed basis. Please call early in the morning if you wish to be seen.

Initial: _____

Phone Calls

The office answers calls from 8:30am-12pm and 1-5pm on Monday through Friday. During other times calls are forwarded to our answering service. The answering service will send the information to either the doctor on call or our nurse telephone triage service. We respond to calls within an hour if possible.

The busiest times for phone calls in the office are 8:30-10 and 3:30- 5. If possible make non-emergent calls during off-peak calling times.

Initial: _____

Insurance Plans

It is your responsibility to keep us updated with your correct insurance information. Please bring your current insurance card to all appointments. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.

If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not yet been informed that we are your primary care physician, you will be financially responsible for your current visit if the insurance company does not cover it.

It is your responsibility to know when you are required to pay a copay and what the copay amount is for each type of service.

It is your responsibility to understand your benefit plan with regard to covered services and participating laboratories/facilities. For example: Not all plans cover annual physicals, sports physicals, or hearing and vision screenings. If these are not covered, you will be responsible for payment.

For children younger than 3 years, there is a limit as to the number of allowable well visits per year. If the number of visits is exceeded, your insurance company will not pay; you will be responsible for payment.

Our lab may not be the preferred lab for your insurance plan. If you are required to use another lab there may be a charge from your insurance if you use our lab. We can provide you with a lab slip to go to another lab if necessary.

It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial: _____

Referrals

Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days.
It is your responsibility to know if a selected specialist participates in your plan.
Your child's doctor must approve referrals before they are issued.

Initial: _____

Financial Responsibility

As required by your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.

Co-payments are due at the time of service. A $3 service fee will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.

Self-pay patients are expected to pay for services in FULL at the time of the visit.

If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.

If previous arrangements have not been made with our finance office, any account balance outstanding longer than 30 days will be charged a $3 re-bill fee for each 30-day cycle. Any balance outstanding longer than 120 days will be forwarded to a collection agency.

For scheduled non-emergent appointments, prior balances must be paid prior to the visit.

The accompanying parent or adult is responsible for full payment at the time of service. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our office manager promptly for payment arrangements and assistance in the management of your account.

We accept cash, checks, credit or debit cards (Visa, Mastercard, or Discover).

A $25 fee will be charged for any checks returned for insufficient funds. If you have a returned check your account will be placed on cash or credit card only status.

Please call the office or our billing department if you have a question about your bill. Most problems can be settled quickly and easily, and your call will prevent any misunderstandings. If you are having trouble paying your bill, please discuss the situation with us. Satisfactory arrangements can almost always be made. Financial considerations should never prevent children from receiving the care they need at the time they need it.

If you file for bankruptcy with an outstanding balance you will be given 30 days to transfer care to another physician.

Initial: _____

Forms

There is no charge for the State of RI school form given at the time of your child's annual visit. This is considered part of the visit. However, should you lose the form we provided there will be a $5 charge per form to replace it. Any additional school, camp, or sports forms are subject to a $5-per-form fee. Family and Medical Leave Act forms are $10. Payment is due when the forms are dropped off. We require 5 day turnaround time.

Please fill in your part of the form before dropping it off or mailing including child's name and your signature.

Initial: _____

Transfer of Records

If you transfer to another physician, we will provide a copy of your immunization record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hours' notice. A copy of your complete record is available on CD for $10. Paper copies of records have a $10 minimum charge with $0.25/ per page additional fee for records over 25 pages.

We provide records of your child for visits rendered here at Pediatric Associates only. For any previous records, you must request them directly from your previous doctor(s).

Initial: _____

Prescription Refills

Monthly medication refill requests should be made during regular business hours. Please allow 48 hours for request to be completed. Please plan accordingly. Prescription refill requests for non-controlled medications can be made directly to the pharmacy. The pharmacy will contact us electronically for refill.

Initial: _____

General

Our staff is here to help us provide the best possible medical care for your child. Please be courteous when interacting with our staff

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name_____Relationship_____

Responsible Party Member's Signature _____ Date _____