CHILD & TEEN
Wellness Center

# FINANCIAL POLICIES

The Child & Teen Wellness Center (CTWC) is dedicated to providing our patients with the highest quality health care. We ask for your help by understanding and cooperating with our financial policies. These policies protect our ability to successfully provide care and responsibly adhere to mandated guidelines established by contracted insurance carriers. If you have special financial needs, please let us know in advance. Your familiarity with the following policy statements and your willingness to comply, are imperative for the delivery of our pediatric care. If you need assistance or have questions about insurance related balances, please contact our billing department, between 8:00 a.m. and 4:00 p.m., Monday through Friday.

**PLEASE BRING THE FOLLOWING WITH YOU AT EVERY VISIT:**

1. Current insurance cards
2. Your co-pay, co-insurance and deductible
3. Photo identification

**INSURANCE:**

- A current insurance card must be brought to every appointment so we can verify insurance coverage.
- If you do not bring a current insurance card with you to your appointment, you will be considered a self-pay patient and payment will be due at the time of service (See self-pay policy below).
- If insurance cannot be verified, you will be considered a self-pay patient and payment will be due at the time of service.
- An insurance claim will not be filed if coverage cannot be verified.

If we **DO** participate with your insurance (in-network):

- We will submit all eligible charges to your insurance company for reimbursement.
- Co-pays, co-insurance and deductibles are the patient's responsibility.
- **CO-PAYS, CO-INSURANCE, DEDUCTIBLES:**
  - **Are due at the time of service in accordance to your insurance carrier's agreement and our office policy.**
  - **If the co-pay, co-insurance, deductible or balance is not paid at the time of service, a charge of $20.00 fee will be added to the patient account**
  - **We accept payment by CASH, CHECK, or CREDIT CARD.**
  - **Payment is required regardless of who brings the patient in.**

If we **DO NOT** participate with your insurance company (non-par):

- We will **NOT** file an insurance claim
- Payment for services **IS** required at the time services are provided.
- Patients will be provided with an itemized bill so they can submit to their insurance company for reimbursement.

**SELF-PAY PATIENTS:**

If you **DO NOT** have insurance

- All services provided will be the responsibility of the patient/guardian.
- Payment is required at the time of service or the patient cannot be seen.
- A time-of-service discount of 35% will be given to all self-pay patients.

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**PATIENT BALANCES:**

- Patient statements are sent as a courtesy and payment is expected by return mail.
- It is the responsibility of the patient/guardian to notify the Practice if there is any change of information, such as a change of address, email, phone number, etc.
- Outstanding balances are required and will be collected at check-in regardless of whether or not a statement has been sent.

***FYI: Commercial insurance companies send patients/guarantors an Explanation of Benefits(EOB) notice once a claim has been processed. This notice provides information on how the claim was processed, how much the provider was paid and what the patient's financial responsibility is.***

**POLICY ON DIVORCE SEPARATION & CUSTODY AGREEMENTS:**

CTWC will not honor the specific financial arrangements set forth in a Child Custody Agreement, Divorce Settlement Agreement, Divorce Decree from Judgment, or the like (the "Arrangements"). Since CTWC is not a party to these Arrangements, it is not obligated to the financial terms of these Arrangements. In cases of child custody, the parent who presents their child (the "Presenting Parent") for care and treatment at CTWC is responsible for the payment of co-pays, co-insurance, and deductibles at the time of service. This policy applies whether there is a joint-custody arrangement of the child and/or joint responsibility for their medical expenses. If the child is on the non-custodial or non-presenting parent's health insurance, then CTWC will still collect the applicable co-pays, coinsurance, and deductibles at the time of service from the Presenting Parent. Upon request, CTWC will provide a duplicate copy of your receipt so that the Presenting Parent or guardian can seek reimbursement where appropriate.

**RETURNED CHECK FEE:**

- A return check fee of $38.00 will be charged for all retuned checks.
- The $38.00 return check fee and the outstanding balance must be paid within 30 days.
- If payment is not received within 30 days your account will be considered for collections.

**COLLECTIONS:**

- Our Practice is obligated by the terms and conditions our in-network contractual agreements with insurance carriers to make a good faith effort to collect patient balances, such as copays, co-insurance and deductibles.
- **If no payment has been received on a patient/family's account for a period of 90 days, or payment plan agreements have not been kept, an account will be sent to collections.**
- Patients will receive notification that their balance is 90 days past due and their account is being sent to collections. They will also be notified that their family is being discharged from the practice. Patients sent to collections risk having their credit impacted.
- The Collection Agency charges a fee to the Practice for their services. These fees will be transferred into the patient's account balance increasing the amount owed to our office. It is the patient's best interest to make prompt, routine payments to avoid unnecessary fees.
    - Fees are as follows
    - Balances of $75.00 and higher will be charged an additional 33% based on the outstanding balance.
    - Balances less than $75.00 will be charged an additional 40% based on the outstanding balance.

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**CANCELLATION POLICY:**

- 24-hour advance notice is REQUIRED if you are unable to keep an appointment.
- A $40.00 fee is charged if an appointment is not cancelled 24 hours in advance.
- A $60.00 fee is charged if the appointment was for a consultation visit.

**MISSED APPOINTMENTS:**

- A fee of $40.00 is charged for all missed appointments.
- A $60.00 fee is charged if the appointment was for consultation visit.
- **If you "No Show" 3 times, we reserve the right to discharge your family from the practice.**

**AFTER HOURS TELEPHONE CALLS:**

After hours, telephone calls will be charged a $25.00 fee. This includes calls received after:

- Weekdays after 5:00 p.m.
- Sundays after 10:30 a.m.
- Saturdays (Office Closed) and holidays all day

**FORM FEE CHARGES: (patient must have a current well exam on file)**

- The fee for the completion of health forms on a per form basis:
    - $5.00 SIMPLE form
    - $10.00 STANDARD form allow 7-10 business days for completion
    - $25.00 EXPRESS form allow 1-2 business days for completion *(at the discretion of the practice)*
    - $30.00 COMPLEX form allow 3-5 business days for completion
    - Payment is due when the form(s) are received.

**MEDICAL RECORDS COPYING FEES:**

- ALL RECORD REQUESTS MUST BE ACCOMPANIED BY A COMPLETED RECORDS REQUEST FORM.
- Copying fees include 76 cents per page and the cost of postage and handling.
- An additional preparation fee of $22.88 is required if medical records are being sent to any interested party other than the patient or legal guardian. (This fee CANNOT be charged to the patient)
- We require 7-14 days for completion of these requests.
- Electronic copy of patient chart $15.00 plus actual cost of postage.

Initial _____

# NOTICE OF FINANCIAL RESPONSIBILITY BILLING GUARANTOR

Patient name: _____Date of Birth: _____

I have received, read, and understand The Child & Teen Wellness Center Financial Policy.

- I agree to assign insurance benefits to Daniel J. Levy, MD PA/Child & Teen Wellness Center whenever necessary. _____ (initial)

- I agree to pay copayments, coinsurance, deductibles, services not covered by insurance and any outstanding patient balances (if applicable) PRIOR to being seen by a provider. _____ (initial)

- I agree to pay in full at the time of visit if my insurance is not active or cannot be validated. _____ (initial).

- I agree that I am responsible for providing a current referral form at the time of service (before services are rendered). _____ (initial)

- I agree that if I do not show for my scheduled appointment or if I cancel with less than 24 hours' notice I will be charged a fee of $40.00($60.00 for consultation appointment). **I am aware that this fee will not be waived.**

_____ (initial)

- I agree that if it becomes necessary to forward my account to a collection agency because of lack of payment on legitimate patient balances owed to the practice, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections. _____ (initial)

- I acknowledge the same responsibility for the siblings of the above mentioned patient. _____ (initial)

Other children seen at this office:

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

**The parent and/or legal guardian who signs this form is responsible for any and all co-pays, deductibles, co-insurance, and/or unpaid balances not covered by insurance, regardless of marital status.**

Signature: _____

Print Name: _____

Relationship to patient(s): _____ Date: _____