RTC Pediatrics Financial Policy

We are pleased you chose RTC Pediatrics for your child's medical care! We appreciate your cooperation in following our office and financial policies so that we may continue to provide the absolute best care to our patients. Our staff is always ready to assist you with any additional questions you may have.

Respect: We strive to show respect to every person that comes into our practice, **in return**, we appreciate the same. We have a **zero-tolerance** policy for any **disrespectful** or **disruptive** behavior. ***This allows us to ensure a safe and positive healing environment for everyone at our clinic.*** Thank you.

NEWBORNS

Please make sure that you add your newborn to your Insurance Policy within 30 days of birth to ensure coverage and select one of our physicians as your baby's primary care provider if a PCP is required. **Be sure to bring any hospital records regarding your baby's health (including Hepatitis B Vaccination, Hearing Test and Newborn Screen) to your first office visit.**

BILLING AND INSURANCE

We are committed to providing you with the best possible care at a fair price and helping you receive maximum insurance benefits. RTC PEDIATRICS participates in many insurance plans, **it is your responsibility to fully understand your plan and any Health Savings Accounts you may have.**

INSURANCE

Your health insurance policy is a contract between *you* and your Insurance Company. It is particularly important that you understand its provisions. Please review your policy and become familiar with the benefits it provides. If you have any questions about the coverage, you should contact your insurance company directly.

Questions regarding the filing of claims or the responsibility of payment may also be discussed with our billing office staff (703-435-0726). The parent or guardian is always responsible for payment, not the Insurance Company.

We are happy to work with *you* and your Insurance Company. To help make this process easier and less stressful. We would like to suggest the following guidelines:

- Provide a current insurance card to each visit. Some insurance plans have a card for each member. If that is the case, be prepared to provide each child's card at each visit.
- If you have a co-pay, coinsurance, or deductible, please be prepared to pay this at the time of your office visit.
- If you have secondary insurance, please let us know and provide the secondary insurance card at each visit.
- If your plan requires a referral or authorization number to see a specialist, please contact us at least 5 business days prior to your appointment.

PATIENT RESPONSIBITY

Payment METHODS

Patient balances are due within 30 days after insurance pays. If your insurance plan is subject to **routine deductibles and co-insurance,** we require you to keep a credit card on file so we can collect those charges as soon as your insurance carrier designates your financial responsibility for the claim. We will only charge your credit card without prior notice if the claim was adjudicated normally. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment. Please see page 4 of this document for the **Card on File Consent Form**.

We require payment in full at the time of visit if:

- Current insurance information and a current insurance card are not presented at the visit.
- The patient has no insurance coverage.
- We do not participate with your insurance plan.

If the need arises for special arrangements to pay your account balance, please contact the billing office at 703-435-0726.

If charges remain unpaid after 30 days, a second statement will be rendered with a notice requesting immediate payment. If charges remain unpaid after 60 days, a final statement will be rendered with a letter informing you that your account will be placed with a collection agency if you do not pay your bill. You are responsible for any collection costs in addition to your outstanding bill. If you are presently in collection, the practice will use its discretion whether to provide you with further treatment or ask you to find another physician.

Administrative Fees

Missed Appointment Fees

A $50 ($100 June-August) missed appointment fee will be added to your account for all WELL CHILD EXAMS that are missed or not canceled at least 24 hours before the scheduled appointment. If you no show/cancel less than 2 hours of a same day sick appointment, your account will be charged a $50 missed appointment fee.

Additional Fees

School Form	$20/Form (No charge if requested at the time of visit)
School Form Rush Fee	$45/Form (Includes School Form and Rush Fee)
After-Hours Phone Call	$25
Writing a Letter	$20
Returned Check Fee	$20
Copy of Medical Records	$50
Late Co-Pay > 1 Week	$15
Balance Past due>30 days	1.5% late charge/month until payment received.

Travel Visits

Travel visits and vaccines may not be covered by your insurance company. Please check with your insurance prior to the visit. If these are not covered by your insurance, the cost of the visits and vaccines will become patient responsibility.

If you receive a statement that shows an amount due as patient responsibility and feel it is incorrect, please contact your insurance carrier or our office immediately. There are some instances in which your insurance will deny claims incorrectly. They can deny due **to Coordination of Benefits**, meaning your medical claims will not be paid until your insurance receives word from the policy holder informing them of any other insurance. **You are responsible for the Coordination of Benefits with your insurance company.** At times the patient's date of birth or Primary Care Physician (PCP) is incorrect with the insurance, these are corrections that need to be made to the policy to facilitate claim payment.

RTC Pediatrics Financial Consent, Privacy Practices and Vaccine Administration Policy Acknowledgement

THE POLICY IN OUR OFFICE IS THE PARENT/GUARDIAN WHO REQUESTS TREAMENT FOR THE CHILD IS RESPONSIBLE FOR ALL FEES FOR SERVICES RENDERED.

Financial Consent

I realize verification of insurance coverage is my responsibility. In the event the listed medical service is not covered by my insurance, I agree to be financially responsible for charges for these services. I verify the information reported regarding my coverage is correct and further authorize the release of any necessary information for any claim to my Insurance Company.
I do by hereby authorize RTC Pediatrics to apply for benefits on my behalf for services rendered. I authorize the release of any medical or other information for the purpose of providing care or securing payment for services rendered. I authorize direct payment of medical benefits directly to RTC Pediatrics.

I understand and agree that I am financially responsible for any charges not covered by my insurance carrier for services provided by RTC Pediatrics including but not limited to co-insurance, copayment, and/or deductibles and agree that I am to pay any of these non-covered charges at the time of service.

I also understand and agree that if my insurance company subsequently notifies RTC Pediatrics that my child is not covered as of the date of service, has no well coverage, has exceeded well-child coverage or service provided is a non-covered service, I am to pay in full the amount not covered upon receipt of the patient statement.

I understand and agree that administrative costs including but not limited to form completion, medical letters of necessity and/or copies of medical records will incur a charge that is the responsibility of the parent/guardian and cannot be submitted to my insurance carrier. I understand and agree to pay these charges either up front or upon receipt of the patient statement as dictated by office policy.

I understand that if you wish to discuss issues beyond the scope of the routine exam during your Well Visit, your insurance company requires you to pay a co-pay, deductible or co-insurance for the Well Child Check.

I understand and agree that fees may be assessed for Well Check appointments cancelled less than 24 hours from the appointment time and no-shows. The fee will be billed and payable upon receipt.

If my account is assigned to a collection agency, I agree to pay all agency fees, court costs and attorney fees. I understand that all accounts with a balance over 30 days will be assessed at a 1.5% late charge per month on the unpaid monthly patient balance.

Acknowledgement of Privacy Practices

I understand that the patient's health information is private and confidential. I understand that RTC Pediatrics works hard to protect the patient's privacy and preserve the confidentiality of the patient's personal health information.

I understand that RTC Pediatrics has a detailed document called the "Notice of Privacy Practices". The document contains more information about the policies and practices protecting the patient's privacy. I understand that I have the right to read the "Notice" before signing this Acknowledgement.

This Notice of Privacy Practices contains a complete description of my privacy/confidentiality rights. These rights include, but are not limited to, access to my medical records; restrictions on certain uses; receiving an accounting of disclosures as required by law; and requesting communication be by specified methods of communications or alternative location. This Notice of Privacy Practices may be updated periodically.

Acknowledgement of Vaccine Administration Policy

I understand that RTC Pediatrics will administer vaccines in accordance with the American Academy of Pediatrics Guidelines. I also understand that I will be given information about these vaccines and the opportunity to discuss them prior to administration.
Vaccines are safe and effective in preventing diseases and their subsequent health complications. For the safety of all our patients, families, and staff, we require all our patients to receive all recommended vaccines by age 2.

Patient Name: ____ **Patient DOB:** __________________

Signature of Parent/Guardian: ___________________________________ **Date:** _______________________

Relationship to Patient if other than parent/guardian: ____

RTC Pediatrics
Credit Card on File (CCOF) Authorization

Patient Responsibility

In accordance with our Financial Policy, patient balances are due within 30 days after insurance pays. If your insurance plan is subject to **routine deductibles and co-insurance,** we **require** you to keep a **credit card on file** so we can collect those charges as soon as your insurance carrier designates your financial responsibility for the claim. We will only charge your credit card without prior notice if the claim was adjudicated normally. During the time you leave a credit card on file, if it expires or otherwise becomes uncollectable, we will expect you to promptly provide a new means of payment.

You may use your credit card on file to pay your co-pay or any outstanding balance due at the time you are seen in the office. Once the claim is reviewed by the insurance company, you will receive an Explanation of benefits (usually a week or two before we receive the same document). If the amount due to RTC Pediatrics is less than $150, we will bill the card on file without prior notification. Our Billing Department will then send you an emailed receipt of any charges that are made to your card via our patient portal. If, however, the balance is $150 or more, we will notify you via the method you select below. You will have 3 business days to discuss any questions or concerns with our billing department, and if we do not hear from you within that time, we will charge your credit card, debit card, or health savings account (HSA) card, the amount due to RTC Pediatrics based on the Explanation of Benefits.

How do you know your credit card is secure with the practice? RTC Pediatrics does not store complete credit card information anywhere in our office or computer system. We swipe the card as if processing a payment, and the information is held by the bank that processes our merchant account. When we later process your insurance claim, we go back to the merchant processing company who commits the transaction for the appropriate amount.

Please fill out this form as completely as possible. The information will be sent securely to our office.

List Child(ren)'s names and DOB:

Patient Name: ____ DOB:_____/_____/__________

Patient Name: ____ DOB:_____/_____/__________

Patient Name: ____ DOB:_____/_____/__________

Patient Name: ____ DOB:_____/_____/__________

Patient Name: ____ DOB:_____/_____/__________

Patient Name: ____ DOB:_____/_____/__________

By signing below, I agree to RTC Pediatrics' credit card on file policy, and I authorize RTC Pediatrics to keep my signature and valid credit/debit card number securely and confidentially.

Signature: ____ Date: _____/_____/________

RTC Pediatrics CREDIT CARD ON FILE AUTHORIZATION

Name on card: ____

Card Type:

_____ American Express

_____ Discover

_____ Master Card

_____ Visa

_____ HSA

Card#: ____

Exp. Date: ______/_____/__________

CVC: ___________

(This information will be redacted from the form)

Billing Address:

Street: ____

City: ____State: _________________ Zip: ___________________

Billing email: ____

Card Holder's Signature: ____ Date: _____/_____/_________