SAMPLE FORM. DO NOT FILL OUT.

Pediatric Endocrine Specialists

FINANCIAL RESPONSIBILITY STATEMENT

Please Read Carefully!

Thank you for choosing Pediatric Endocrine Specialists of Georgia (PES-GA) as your health care provider. As part of your relationship with PES-GA, a clear understanding of our financial policy is important. This will ensure you know what financial actions we will be undertaking on your behalf as well as what your financial responsibilities are to PES-GA.

We require patients to arrange for payment of all billed services at the **time of service**. For patients with insurance, the total costs of services are set by your insurance, and you will be responsible for the portion of that total cost as determined by your particular policy. Uninsured patients will be required to pay the total cost of services. Collecting payments at the time of service helps us to reduce our administrative costs, allowing us to keep the cost of our services as affordable as possible. Consequently, we cannot agree to collect payment at a later date.

We accept cash and most major credit cards (no American Express) for your convenience. At your visit, you will be required to pay an *estimate* of your total cost of the visit, based on your insurance copay, deductible, coinsurance, and your specific benefits on the date of service. Any remaining credit or debit will be determined when your insurer provides us with an Explanation of Benefits (EOB), and a check or bill will be mailed to you. The EOB typically takes 1-4 weeks to arrive, but may take as long as three months.

Insurance: We are contracted with numerous insurance companies, and will file your claim as a courtesy to you. Because every plan has different stipulations regarding payment for services**, it is your responsibility to understand your benefits**. If you do not inform us of any special requirements in your insurance contract, such as referrals or pre-authorization for treatment, and your insurance company does not cover these charges, we will bill you directly. This is also our policy in the event of claim refutations, such as medical necessity or pre-existing condition denials.

You must provide your insurance card or proof of insurance at the time of each visit. **If you do not have insurance, are unable to provide proof of insurance, or are on a plan in which we do not participate, full payment is required at the time of your visit.** It is very important that you become familiar with your insurance plan and understand its benefits. For patients without insurance we expect payment in full at the time of service.

Fees/Collections: Should the account be referred to collections, you shall pay reasonable attorney fees and collection expenses, as well as a 30% service charge of your balance (minimum of $25) as well as any late fees that are accrued. You also understand and agree to pay a $25 service charge for any returned checks.

Cancellations: **We require at least 48 hours notice for any cancellations or rescheduling of a previously scheduled appointment**. We appreciate you as a patient, and your cooperation in complying with this policy will assist us in providing the best care possible to all of our patients. Failure to cancel or reschedule appointments at least 48 hours in advance will result in a **$25 administrative fee for follow-up** appointments and a **$50 fee for new patient** appointments. These fees are not covered by your insurance company and are the sole responsibility of the guarantor on the account. If you miss two appointments consecutively or three within a 12 month time frame without adequate notice, you may be discharged from the practice.

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Medical Records and Itemized Statements: Medical records are the property of PES-GA. You can request copies of your medical record in writing. We will provide copies of required medical records to other medical practitioners free of charge. All other copies will be charged a rate to cover the costs of staff time and copying. This rate is $20 for records less than 40 pages and $0.50 per page for records over 40 pages. Itemized statements for tax purposes will be provided for a flat rate of $10. We will provide you with your copies within 30 days of receiving your written request.

Miscellaneous Fees: As you know, the entire health care industry is undergoing an unprecedented amount of change that is affecting us all. Insurance companies and the government are lowering reimbursements, changing what they will cover and mandating expensive, new business practices. As a result, we need to charge for certain requests. These additional charges are not meant to impede patient care, but to allow the physicians and staff time to address all of our patients' needs. The charges are intended to represent the time required for the service provided.

- NON-EMERGENT AFTER HOURS CALLS - $20
  These are calls that should be made during normal business hours. Examples include after hours calls to request a prescription refill, or calls to review blood sugars or other aspects of routine diabetes care.
- EXPEDITED TEST & LAB RESULTS - $50
  We try to give reasonable estimates on when test results should be expected and schedule follow up visits accordingly. We understand and share the anxiety of waiting for results. When a patient requests results sooner than we expect them to return, this requires significant effort to expedite.
- GROWTH HORMONE ADMINISTRATIVE FEE - $100
  This fee offsets the cost of the large volume of administrative paperwork required by insurance companies to obtain approval and renewal of growth hormone. This fee is payable before starting the process of obtaining approval for growth hormone.
- SCHOOL/CAMP/FMLA/OTHER FORMS - $20

Please remember that you, the patient, are ultimately responsible for payment on your account. If you have any questions regarding our financial policy or your account, please call our office.

NOTICE OF BALANCE PAYMENT

Please read the following Notice of Balance Payment:
You agree to make a payment, or payment arrangements, on any outstanding balance you may have accrued prior to being seen at every follow-up appointment with us.

By signing below, I agree to abide by the Financial Responsibility Statement and the Notice of Balance Payment.

Guarantor of Account Signature: _____ **Date:**_____

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