**FINANCIAL AGREEMENT**

Our commitment to provide excellent medical care of your children comes with financial responsibilities. In order to ease the transition from the practice of medicine to the business of medicine, Stepping Stone Pediatrics, LLC, has adopted the following policies. Please contact our billing office with any questions.

**PAYMENT DUE AT TIME OF SERVICE**

* Copays are due at the time of service, regardless of who brings your child in to be seen. Please make arrangements for payment prior to your child arriving at our practice.
* Payment is expected for any outstanding balance on the account at time of service. At your request, we will be happy to provide an itemized statement for your records.
* Self-Pay patients are expected to pay at time of service. A prompt pay discount will be applied to Self-Pay balances paid in full on the date of service.
* **For separated or divorced parents, copays and balances are due at the time of service. Stepping Stone Pediatrics will not be placed in the middle of any financial agreement or dispute between parents. We will be happy to provide you with a detailed receipt for reimbursement from the other party.**

**INSURANCE (In-Network)**

* Proof of insurance must be shown at check-in at every visit. Please make sure to bring your card to every visit. Without proof of insurance you will be considered Self Pay and payment in full will be due at time of service.
* Newborn insurance – Getting your new baby on your insurance plan requires some effort on your part. Please see our Newborn Insurance Waiver for more details on expectations for new parents.
* If your insurance requires a primary physician (PCP) to be named (HMO and/or POS usually), please verify that Dr. Kim at *Stepping Stone Pediatrics* is listed as the chosen provider prior to your appointment. Failure to do so will cause a denial of the claim. Claims denied for incorrect PCP selection will become your financial responsibility.
* **While we file insurance as a courtesy, you are ultimately responsible for verifying that we are in network with your INSURANCE CONTRACT (not just insurance company). Please familiarize yourself with your plan’s copayment, co-insurance, and deductible requirements annually. These charges are your financial responsibility.**
* We will file secondary claims once as a courtesy only for insurances for which we are In-Network. If your secondary insurance denies the claim or fails to respond within 30 days, the account balance will revert to your responsibility.
* We do not bill tertiary insurances.
* We do not bill Third Party Insurance such as Worker’s Compensation or Auto Accident claims.
* Balances not paid by the insurance company through no fault of Stepping Stone Pediatrics will be billed to you directly for payment. These denials could include instances where the insurance company is waiting on you to contact them to coordinate benefits, pick a primary care provider, correct a date of birth, etc.

**INSURANCE (Out-of-Network)**

* We can bill as an out-of-network provider if we do not participate with your insurance **IF** you have out-of-network

benefits. However, it is your responsibility to verify your out-of-network benefits. You will be financially responsible to pay for any visit denied as Out-of-Network and non-payable by your insurance company.

**Initial and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WELL/PREVENTATIVE CARE VISITS**

* While many policies cover these visits in full, many insurance contracts are now applying copays and/or deductibles, regardless of our in-network status with the insurance company. It is ultimately your responsibility to understand your individual contract as we do not have access to the specifics of your contract with your insurance company.
* If during a well visit your child is sick or time is spent on a concern not related to normal growth and development, an office visit may also be charged in addition to the well visit. You will be responsible for any financial responsibilities incurred, including copays, co-insurance, and/or deductibles. It may be more prudent to schedule a separate office visit to go over anything beyond normal growth and development or reschedule the well visit to focus on the more immediate concern.

**BALANCES ON ACCOUNT** – In order to ensure that we can continue to provide the level of care you have come to expect from us, the information following outlines how we will be handling balances on the patient account.

* Financial statements will be mailed out approximately every 30 days. Payment is expected upon receipt of the financial statement. Failure to pay your account balance(s) could ultimately result in your account being sent to an outside collections agency and/or your family being discharged from our practice. Reinstatement, if allowed, will require payment in full plus any associated fees.
* If you have any special financial needs, please let us know as soon as possible by speaking with a member of our billing department, in person or by phone. We are willing to work with our parents as best as possible to meet their needs and to continue providing care to our patients.
* Structured Payment Plans are available. All payment plans must be secured with a credit card and a payment plan agreement must be signed. The payment plan agreement will offer details on how your account will be handled during the duration of the agreement.

**HIGH DEDUCTIBLE PLANS** – We understand that many insurance policies now have high deductibles in exchange for lower monthly rates. We understand it is well within your right to not file insurance and to pay out of pocket in an attempt to lessen the financial impact of these high deductible policies. Should you decide to be “Self-Pay” in order to avoid paying a high deductible, we will consider your family as “Self-Pay” for the duration of your insurance contract, regardless of visit type. We will not file a preventative visit for 100% payment and then not file an office visit due to deductible concerns. Stepping Stone Pediatrics feels it is in your best interest to file all claims to your insurance company. Please understand that we have payment plans to help you meet the financial burdens of your insurance.

[**http://fairhealthconsumer.org/index.php**](http://fairhealthconsumer.org/index.php) **-** This is a great resource in helping the general public navigate their insurance and understand what everything means through videos, glossary, Health Insurance 101, and other educational materials.

**VACCINATION SCHEDULES** – Stepping Stone Pediatrics adheres to the guidelines set forth by the CDC, the AAP, and the AAFP in the vaccination of our patients. Any decision to alter this schedule will need to be discussed with and agreed upon by your practitioner on a case by case basis. **Please be aware that some insurance companies are denying payment for immunizations administered in a manner that deviates from the CDC approved vaccination schedule**. You will be financially responsible for payment of a vaccination due to denial for this reason – and vaccines are extremely expensive!

**MEDICATION REFILLS**

Please have your pharmacy contact us directly for any medication refills. We require 3 business days for a refill to be authorized. Expedited prescription requests will be processed as quickly as possible but cannot be guaranteed and may be assessed a service fee of $25.

**Initial and Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NO SHOW/MISSED APPOINTMENT POLICY**

* The policy covers the entire family, not just an individual child.
* A “No Show” is considered 1) a Well Check appointment(s) cancelled with less than 24 hour notice, 2) a Same Day Sick appointment(s) that is missed without notification, or 3) any other scheduled appointment that is missed without notification.
* FIRST NO SHOW by any family member in a 12 month period – a notification letter will be sent advising the patient of the missed appointment and the “No Show” policy. No charge will be assessed on your account.
* SECOND NO SHOW by any family member in a 12 month period – a second notification letter will be sent alerting the parent/guardian of the missed appointment and a $25 fee will be assessed on the patient’s account.
* THIRD NO SHOW by any family member in a 12 month period – Dismissal from the practice will be suggested to the physician. If dismissed from the practice, a discharge letter will be mailed to the parent/guardian. If the family is not dismissed from the practice, a $100 fee will be assessed on the patient’s account. The parent/guardian will receive an invoice and this must be paid in full prior to the next appointment being scheduled.

**COST OF FORMS COMPLETION**

Patient forms often take considerable time for our clinical staff to complete and removes that clinician from the ability to offer patient care. Please allow 5 business days for all paperwork requests. All required government forms and most straightforward paperwork will be completed without charge. We will contact you when all forms have been completed to arrange pick up.

**COST OF MEDICAL RECORDS**

Medical records requested from our office to be sent directly to another medical provider will be done at no charge. Medical records for personal pick up will be assessed as follows: $0 for medical records to be placed on a new “unopened” disk or thumb-drive you provide or $5 for medical records to be placed on a disk we provide. As printing has become very costly, we must follow state regulations in billing for medical records; therefore, the fee for printed records will be based upon the Georgia Department of Community Health designated fee schedule. When the records have been printed, we will contact you to notify you that they are ready and the cost incurred. This must be paid in full before we will release the records to you. A copy of the state of Georgia regulations is available upon request. If the records need to be certified, there will be an additional $5 fee assessed per record.

**RETURNED CHECKS**

As a courtesy, we do accept personal checks. We do not accept third party checks. Any check that is returned to us for any reason will be subject to a service charge. The first returned check will be charged a fee of $25 or 5% of the face value, whichever is greater, plus any costs we incur because of the dishonored check. The second returned check will be charged a fee of $30 or 5% of the face value, whichever is greater, plus any costs we incur because of the dishonored check. A letter will be mailed to the family and all returned checks plus applicable fees must be paid by cash, cashier’s check, money order, or credit card within 10 days of the receipt of the letter per Georgia law (Section 16-9-20 pf the Official Code of Georgia). After a second offense, we will no longer accept checks on your family account.

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**