El Paso Pediatric Associates, P.A. Financial Policy and Consent (2019)

We are committed to providing your family with the best possible pediatric care. Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below and that you will be financially responsible for any and all charges not paid by your insurance.

BILLING YOUR INSURANCE:

- Please present your current health insurance card at each office visit.
- Our office will bill validated **Primary Insurance** as a courtesy. You must pay for any patient responsibility.
- If you have **No Insurance** then payment in full is required at the time of service.
- Know your insurance and **REMEMBER: Non-covered services such as vaccines can be VERY EXPENSIVE**.

PAYMENT FOR SERVICES:

- Co-pays, co-insurances, and deductibles must be paid at the time of service. _____**please initial. .**
- We mail statements on a weekly basis. Payment is due upon receipt of your statement.
- **Additional Fees include: Nurse Forms, Same day Referrals, Same day Prescriptions, Controlled Substance Prescriptions, After-Hours Fee, and other required forms._____please initial**
- **We require a valid credit card be kept on file to cover any past due balance. Please see the next page.**
- **Past Due accounts will be "Flagged" as "Past Due" and could delay or prevent scheduling an appointment until payment arrangements have been made.**

RETURNED CHECKS:

- **The charge for a non-sufficient funds (NSF) check is $35**. You must pay in full for the NSF check and NSF fee within 10 days of notice. If payment is not received by the due date, we will forward the returned check to the District Attorney's office. It is a felony to knowingly write a bad check. For the next 12 months, cash or equivalent payment at the time of service is required.

COLLECTION ACCOUNTS:

- When an account remains unpaid after 90 days we reserve the option to refer the account to an outside collection agency. **If your account is sent to an outside collection agency, there will be a 40% surcharge added to your balance.** EPPA reserves the right to reschedule or deny future appointments for delinquent accounts. If your account is sent to a collection agency you may be asked to find another provider._____**please initial**

LATE ARRIVALS, CANCELLATIONS AND NO SHOWS:

Please arrive 10 minutes prior to your scheduled appointment to allow for check-in and any paperwork.

- We require a **24-hour notice** to cancel or reschedule an appointment. For appointments scheduled within 24 hours of the appointment time, a 2-hour notice is required. **If you arrive 15 minutes late to your appointment, you have missed your appointment; therefore, a late cancellation fee could be charged, whether you are seen then or not.**
- Failure to give proper notice for cancellation or reschedule will result in:
  - A $25.00 charge for "Late Cancellations", per child
  - A $25.00 charge for the "Missed Appointments", per child
  - Your family could be subject to dismissal for "Chronic Missed appointments".
- **Please initial that you understand the fees above._____**

***** I acknowledge and understand the office policies and procedures explained above and have received a copy. I hereby authorize my insurance company to pay El Paso Pediatric Associates, PA directly. A copy of this authorization can be considered an original for insurance purposes.

***** I do hereby consent to and authorize the performance of all examinations, treatments, and medical services by El Paso Pediatric Associates, PA and their staff, which may be deemed advisable. My signature on this document indicates that I have read, understand and agree to the policies outlined in this document.

_____ _____

Signature Date

_____ _____

Print Name Relationship to Child(ren)

Child/Children's Names and Date(s) of Birth: _____

_____

_____

_____

El Paso Pediatric Associates, PA Payment on File Policy (2019)

Your signature at the end of this document will indicate that you have read, understand and agree to the policies outlined below.

El Paso Pediatric Associates, PA (EPPA) requires that a valid credit card be kept on file.

This policy is designed to:

- Help you avoid all billing related fees
- Streamline the billing process in our office and eliminate the expenses related to handling overdue accounts
- Focus our time and energy on your children and their medical care

The card information is stored electronically in an encrypted form and cannot be viewed by our office staff. Your signature will authorize the card to be used 14 days after your balance becomes due.

How the policy works:

1. At the time of registration or check-in, you will be asked for your credit card information to be electronically stored in encrypted form in our computer. Only the last four digits are visible to our staff.
2. As before, we will bill your insurance carrier as a courtesy for all charges related to the visit.
3. When we receive an explanation of benefits (EOB) from your insurance, we will send you a statement the following week. If we have not received payment within 14 days, we will charge the credit card on file for the balance due (on statement). Please call 1-866-371-6118 Ext 124 to make payment arrangements if necessary.
4. If EPPA attempts to use your card and it is declined or has expired, EPPA will send you a new statement with a note asking for current credit card information.

Please remember that this policy does not restrict your right to appeal any charge made to your credit card. Should you feel that we have charged your card in error, you may contact our billing office. If a mistake has been made we will reverse the charges.

I have reviewed a copy of El Paso Pediatric Associates, PA billing policy and agree to provide my credit card information to El Paso Pediatric Associates, PA for the sole purpose of payment for my child(ren)'s medical care.

_____ _____
Signature of Authorized User Date

_____ (__ __ __) __ __ __ - __ __ __ __
Print Name as it appears on your Credit Card Phone Number of Cardholder/Acct Holder

Billing Address: _____

_____

El Paso Pediatric Associates Credit Card/Debit Card/Health Savings Account on File

PCC Account # _____

Until further notice I, _____ authorize El Paso Pediatrics to charge the patient-responsible balances on my account to the following credit card:

Circle One:

Visa MasterCard
Discover American Express

Credit card #: _____ _____ _____ _____ .

Exp. Date (mm/yy):____ / ____ Three digit security code (on the back of the card): _____ (front of Card for AE)

We will enter your card information into the secure credit card processing website.
I understand El Paso Pediatrics will send notice prior to running my payment, and I have the right to use another form of payment.

Updated 09/18/2019