





## OFFICE FINANCIAL POLICY

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please sign in at the front desk and present your current insurance card at every visit. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your child's behalf. **IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.**
2. If we are your primary care physician, make sure our name or phone number appears on your card. If your insurance company has not been informed that we are your primary care physicians as of this date, you may be financially responsible for the visit.
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. We do not submit to secondary insurance plans. If you have secondary insurance, we will provide you with a receipt to submit for reimbursement. Your secondary insurance will send the reimbursement check directly to you. **YOU ARE RESPONSIBLE FOR ANY BALANCE ON YOUR ACCOUNT.**
5. It is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered.
6. If our physicians do not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid prior to the visit.
7. If you have no insurance, payment for an office visit is to be paid at the time of the visit.
8. Co-payments are due at time of service.
9. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due *within* 10 business days of your receipt of your bill.
10. If previous arrangements have not been made with our finance office, any account balance outstanding greater than 28 days will be charged a **\$5 re-bill fee**. Any balance over 90 days may be forwarded to a collection agency. In the event of non-payment of any amount due to this practice after 90 days, I agree that in addition to the original amount due, I am fully responsible to pay collection fees of 33 1/3% of the amount due, court costs, and reasonable attorney's fees incurred by this practice if required to collect my debt owed.
11. **All patient families are required to have a credit card on file starting January 1, 2022. Will notify you if we charge more than \$200.**
12. We require 24-hour notice for canceling any appointments. There will be a **\$25 charge for missed sick and well appointments**. Some appointments which are booked with extended time like nutrition, mental health or behavior visits will be charged **\$50**
13. A **\$20** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred
14. There is a **\$10 fee for each form** that is requested outside of an office visit. Please allow at least 48 hours for us to complete forms.
15. We may charge **\$5** per child to copy or transfer medical records.
16. Advance notice is needed for all non-emergent referrals, typically 3 to 5 business days. It is your responsibility to know if a selected specialist participates in your plan. Remember your primary care physician must approve referrals before being issued.
17. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual healthy physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
18. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.

19. When issues are brought up during a well visit, these may go beyond the scope of the well visit and result in referrals, prescriptions and/or significant extra time. This may require us to bill for sick visit complaints and your insurance may require a copay.

**ACKNOWLEDGMENT OF OUR FINANCIAL POLICY**

I have read and understand this office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s) \_\_\_\_\_

\_\_\_\_\_  
Responsible party member's name                      Relationship

\_\_\_\_\_  
Responsible party member's signature                      Date

**ACKNOWLEDGMENT OF OUR NOTICE OF PRIVACY PRACTICES**

I hereby acknowledge that I have received or have been give the opportunity to receive a copy of [Yum Pediatrics](#) Notice of Privacy Practices. By signing below I am “only” giving acknowledgment that I have received or have had the opportunity to receive the Notice of our Privacy Practices.

Patient Name(s) \_\_\_\_\_

\_\_\_\_\_  
Parent/guardian name (if patient is a minor)

\_\_\_\_\_  
Parent/guardian name (if patient is a minor)                      Date

**PHARMACY RELEASE**

We are able to access medication history electronically making it easier for us to understand which medications you or your child has taken in the past.

I give my signed consent to Yum Pediatrics to obtain my medication history.

Patient Name(s) \_\_\_\_\_

\_\_\_\_\_  
Parent/guardian name (if patient is a minor)

\_\_\_\_\_  
Parent/guardian name (if patient is a minor)                      Date