ABCD PEDIATRICS FINANCIAL POLICY

(Effective July 1, 2015)

Thank you for choosing ABCD Pediatrics as your children's health care provider. We appreciate your trust in us and the opportunity to carry out our mission statement, *"To provide caring and informed attention to your children's health and wellbeing as they grow and thrive into adulthood."*

Our office and physicians make a great effort to get insurance companies to pay their share of the cost of this care in a timely manner. However, due to the recent changes brought on by the Accountable Care Act, this is becoming more challenging. We have therefore implemented a new Financial Policy; please read and sign the policy acknowledgement form. If you have any questions, please ask to speak with the Office Manager.

PATIENT PAYMENTS

Payment (co-payments or co-insurance) is due at the time of service. If your child/children have an outstanding balance, please make sure whoever accompanies the patient to the visit is prepared to pay it. We accept cash, check, or a credit/debit card to pay your account. **A current credit card will be kept on file.** Please give your credit card to the front office staff to scan into your account with this form. (Our software securely encrypts and stores your credit card information displaying the last 4 digits of your credit card number only. No employee or outside vendor will ever have access to your information.) The credit card will be encrypted and stored into your secured patient file, and used to cover your balance according to the terms of this policy.

FIRST STATEMENT

Your insurance policy is a contract between you and your insurance company. This contract requires that we collect certain co-payment or prepayment amounts depending upon the type of insurance and insurance carrier at the time of service.

Regardless of your insurance status, when we determine that you owe a balance, we will mail a statement to the mailing address provided to us by you. If your address changes, you are responsible for notifying us. All statements are also available on our secure patient portal. Payment is due upon receipt of the statement.

Please contact our office as soon as possible after receipt of your statement should you have any questions, or should you wish to discuss the outstanding balance. Should you need it, we can help you set up a payment plan with a valid credit card. One-third (1/3) of the total balance is due the first day of the payment plan. The credit card used will automatically be charged for the second and remaining third owed on a monthly basis. We require payment plans to be arranged before your bill is 30 days old. In the event that your insurance pays us after that time, you will be reimbursed.

PROMPT PAY DISCOUNT

ABCD Pediatrics provides a prompt pay discount to those uninsured patients who pay for services at the time of service, thereby avoiding billing and collection costs by the practice. These discounts are set at 30% off the retail price of a Sick Office Visit and 50% off the retail price of a Preventative/Well Office Visit. Discounts do not apply to any services other than office services. Prompt pay discounts are not offered to insured patients where ABCD Pediatrics is contractually required to accept a specific fee schedule. However, we do everything we can to mitigate the expense of anyone who is underinsured.

SUBSEQUENT STATEMENTS AND UNPAID BALANCES

If your account remains unpaid, subsequent statements will be sent to the address we have on file. Although ABCD Pediatrics *does not charge* interest for amounts past due and left unpaid by insurance or patient, a $5.00 statement fee will be included for additional statements sent on unpaid balances.

When your balance is 90 days past due, your credit card will be charged for the full amount owed. If declined, your account will be frozen and turned over to an outside collection agency for non-payment. Collection agency balances require that we will no longer be able to provide healthcare services to your child/children. We continue to provide 30 days of emergent care to give you time to find another physician, and we work with you through any current treatment plans. In this event, the Guarantor of the account agrees to pay any fees incurred by the collection agency.

INSURANCE COVERAGE

While we make a good faith effort to verify your coverage, we are not liable to guarantee that the information given to us by your insurance is correct. It is your responsibility to know what services may or may not be covered by your insurance. We encourage you to refer to your benefits manual if you have any questions about covered services and work with us to make sure that these services are provided at the most cost efficient manner.

I agree to provide ABCD Pediatrics with the most current and accurate insurance information as it applies to my child's account. I will notify the office of any changes to insurance agree to the assignment of benefits. Finally, in the event that insurance information you provide delays payment, you will be asked to pay in full billed charges and seek reimbursement from your insurance provider directly. The insurance company gives us a very small window in which to file a claim, and incorrect insurance information usually delays this beyond their window.

THIRD PARTY PAYORS

Our office does not bill third party payors, such as motor vehicle accident claims or worker's compensation claims. If you wish to see our doctors for a visit that would normally require us to bill a third party payor, you are required to pay for the visit and/labs in full as a self-pay patient, and we will provide you with what you need to submit the claim yourself.

CHILD ADVOCACY

As an advocate for our young patients, ABCD Pediatrics will not intervene in any custody dispute or financial responsibility dispute between parents or other responsible parties. We will send statements to any one address provided; however, we cannot look to more than one party for financial responsibility.

MISSED/LATE CANCELLED APPOINTMENTS

We require a 24 hour notice for cancelation of a Preventative Visit/Well Check-Up, and a 2 hour notice for a Sick Appointment. This courtesy will allow others to be seen in a timely manner. If you are more than 15 minutes late for your scheduled appointment, the physician will have to determine whether the appointment will need to be re-scheduled. Missed appointments will be subject to a NO-SHOW fee as follows**:**

1st Missed Appointment $35

2nd Missed Appointment $75

3rd Missed Appointment $100

After the 3rd No Show, you may be asked to find another healthcare provider.

FEES

ABCD Pediatrics reserves the right to charge the following fees:

Medical Records	$25.00
School/Sports/Camp/Daycare	$ 5.00
Authorization for Services/Medication	$ 5.00
FMLA Paperwork	$25.00
Missed Appointments/No Show Fees	$35/$75/$100
Emergency Walk-in Fee	$25.00

We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak with the Office Manager if you have any questions, comments, or concerns. We thank you for your support and look forward to serving you in the future.

ABCD Pediatrics
NOTICE OF PRIVACY PRACTICE

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

ABCD Pediatrics Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We will abide by the terms of this notice.

Uses and Disclosures
Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated. NOTE: If you pay out-of-pocket in full for the care or service provided, you have the right to ask us to restrict the disclosure of that information to your health plan.

Health care operations: Your health information may be used as necessary to support the day-to-day activities and management of Pediatrics. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Individuals involved in you care or payment for your care: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

Research: When a research and its privacy protections have been approved by an Institutional Review Board or privacy board, we may release medical information to researchers for research purposes.

Law enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures that require your authorization: Disclosure of your health information or its use for any purpose other than those allowed or required by law requires your specific written authorization. Examples of these would be psychotherapy notes, marketing or fundraising activitiies. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information
Appointment reminders and testing results: Your health information will be used by our staff to send you appointment reminders. We may also contact you to provide results from exams or tests and to provide information that descibes or recommends treaments for your care.

Business Associates: There are some services provided in our organization through contacts with business associates. Examples are billing or copying services, etc. We may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Information about treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights
You have certain rights under the federal privacy standards. These include:

- **The right to receive a printed copy of this notice**

- **The right to inspect and copy your protected health information**
  This means that you may inspect, and obtain a copy of you complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper and electronic copies as established by professional, state or federal guidelines.

- **The right to request restrictions on the use and disclosure of your protected health information**
  This means you may ask us in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it , except in emergency circumstance when the information is needed for your treatment. In certain cases, we may deny your request for restriction. You have the right to request in writing, that we restict communication to your health plan regarding a specific treatment or service that you or someone on your behaf, has paid in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

- **The right to receive request and alternative means of confidential communications concerning your medical condition and treatment**
  This means that you have the right to ask us to contact you about medical matters using an alternative method and to a alternative destination (i.e., cell phone number or alternative address, etc.) designated by you. You must inform us in writing, using the form provided by our practice. We will follow all reasonable requests.

- **The right to amend or submit corrections to your protected health information**
  This means that if you believe that the information in your health record is incorrect or that information is missing, you have the right to request that we correct the records. Your request must be in writing and include the reason you are requesting the change. In certain cases we may deny your request.

- **The right to receive an accounting of how and to whom your protected health information has been disclosed to entities or persons for reasons other than treatment, payment or healthcare operations**

- **The right to receive notification following a breach of unsecured protected health information**

Right to Revise Privacy Practices As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting The Privacy Officer at the address below. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Contact Person
If you would like to submit a comment, concern or complaint about our privacy practices, you can do so by sending a letter or contacting the Privacy Officer with your concerns to:

Privacy Officer
ABCD Pediatrics
19238 Stonehue
San Antonio, Texas 78258
210-494-2223

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Revised Effective Date : April 1, 2015

ABCD Pediatrics
Patient Authorization
Please read, initial, and sign below.

(Initial)_____ **Financial Policy**: I acknowledge that I received, reviewed, and agree to comply with the most recent version of the ABCD Pediatrics Financial Policy dated July 1, 2015.

(Initial)_____ **Financial Responsibility**: I understand that I am ultimately responsible for payment on my child's/children's account. Payment is expected at the time of service. I understand I am responsible to pay my co-pay, co-insurance, or deductible according to my insurance contract at the time of service.

(Initial)_____ **Insurance Coverage**: I understand that I am responsible to provide ABCD Pediatrics with my current insurance coverage information and insurance card at each and every visit. I will be responsible for paying any balances due as a result of not providing my most current insurance information. I understand that ABCD Pediatrics will not retroactively file claims due to my failure to provide current insurance information.

(Initial)_____ **Assignment of Benefits**: I hereby authorize payment directly to ABCD PEDIATRICS, for medical benefits otherwise payable to me. I authorize my insurance company to disclose to ABCD PEDIATRICS, information regarding my insurance coverage, including, but not limited to verification of my examination and/or treatment to my insurance company and/or other third party payor.

(Initial)_____ **No Show Fee**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics No Show Policy and agree to pay any fees incurred from failure to comply.

(Initial)_____ **Fee for Forms**: I understand that I received notice about the fee for all forms to be completed by ABCD Pediatrics and I agree to pay prior to form completion.

(Initial)_____ **Privacy Policy**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics Privacy Policy.

(Initial)_____ **Immunization Policy**: I acknowledge that I received, reviewed, and agree to comply with the ABCD Pediatrics Immunization Policy.

(Initial)_____ **Consent to Treat:** I have the legal right to consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to the medical care, treatment and diagnostic tests that providers of ABCD Pediatrics believe are necessary for my child. I understand that by signing this form, I am giving permission to the doctors, nurses, and other healthcare providers in this medical office to provide treatment to this child as long as my child/children are a patient in this practice.

(Initial)_____ **E-Prescribing:** I voluntarily authorize ABCD Pediatrics to allow E-Prescribing for patient's prescription, which allows healthcare providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medical dispense history as long as this child is a patient at this office.

(Initial) _____I understand I am able to withdraw my consent at any time by contacting ABCD Pediatrics in writing at 19238 Stonehue, San Antonio, TX 78258.

Patient Name: _____ DOB: _____

Siblings: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Parent/Guardian name (Print): _____

Parent/Guardian Signature: _____

Today's Date: _____