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ABCD PEDIATRICS FINANCIAL POLICY

(Effective January 1, 2019)

Thank you for choosing ABCD Pediatrics (“ABCD”) as your children’s health care provider. We appreciate your trust in us and the opportunity to carry out our mission statement. *“Best Care. Every Patient. All The Time.”*

Our office and physicians are committed to providing you with the highest quality care at a fair and reasonable cost. To accomplish this goal, we are requesting your help in avoiding unnecessary billing issues that may happen because of incorrect insurance information.

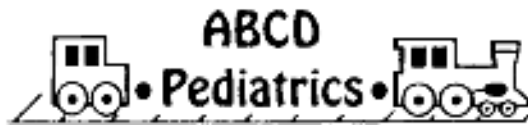
The following is a copy of our payment policy. Acknowledgement and understanding of this Financial Policy must be signed. **Patients cannot be seen unless the statement is signed.**

PAYMENT IN FULL IS DUE AND EXPECTED AT TIME OF SERVICE

Payment is required at the time services are rendered: This includes applicable coinsurance, deductibles, copayments, and previous balances for services not covered or denied by the insurance company. Our software securely encrypts and stores your credit card information displaying the last 4 digits of your credit card number only, and PCI compliance runs regularly on all ABCD devices. No ABCD employee, 3rd party, or outside vendor will ever have access to your information. For your convenience, a current credit card is required to be kept on file. Please provide your credit card to the front office staff to be linked to your account with the Patient Authorization Form. The credit card on file authorizes ABCD to run your card for any balances due after all insurances have processed. The ABCD Billing Department will send out a statement for any patient responsibility after insurance has completed processing the claim. The Credit Card on file will be run for the balance after no response is made after 30 days. (For balances \$200 or greater, The ABCD Billing Department will also try to contact parent/patient by phone and/or email.)

Self-Pay Accounts: If you do not have insurance, please come prepared to pay for your visit in full. ABCD offers a discount for all self-pay services. If payment cannot be made in full at time of service, a payment plan can be made to have the service paid within 90 days, with the first payment payable the day services are rendered.

Our vision: To deliver innovative health care that strives to anticipate the needs of our children and families as they grow and thrive into adulthood.



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Returned Check Fee: There is currently a \$30 fee for any checks returned by the bank. Cash or credit card payments will be required for any account with more than one Returned Check Fee in a twelve-month period.

Missed Appointment Fee: Missed Appointments represent a cost to ABCD, you, and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to any Well Child/Preventative Care appointment and 2 hours prior for any sick visits. A “No Show” fee of \$35 will be assessed upon review of your account if appointment is not cancelled within the timeframe stated. Multiple no shows, per family, within a twelve-month period may result in dismissal from the practice.

Walk-In Fee: It is requested that all patients call and schedule an appointment prior to coming into the clinic to be seen by an ABCD Physician or Nurse. Should a patient walk-in without a scheduled appointment, there will be a \$25 fee assessed.

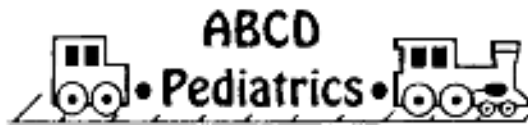
ABCD Pediatrics accepts cash, personal checks, debit cards, Visa, Master Card, Discover and American Express.

BRING YOUR CURRENT INSURANCE CARD TO EVERY VISIT

INSURANCE FILING AND ASSIGNMENT OF BENEFITS

Regarding Insurance: As a courtesy to our patients, ABCD will file claims to any insurance carrier with whom we are participating providers. It is the responsibility of the cardholder to know what their eligibility and coverage is with their insurance carrier. If this is not known, it is suggested the cardholder verify coverage limitations prior to appointment date. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion not covered by your insurance. If the insurance company has not processed and paid the claim within a timely manner or has denied the claim, payment of the account in full becomes the responsibility of the person bringing the child to our office for treatment.

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Change of Insurance/Change of Address: Please notify the office as soon as possible of all insurance and address changes. If the guarantor does not notify the office within 15 days of any changes the guarantor is responsible for all charges not paid because of change in insurance coverage.

Payments: Unless other arrangements are approved by us in writing, the balance of your statement is due and payable when the statement is issued. Payment is due within (30) days from the statement date. If you feel that your claim was unfairly denied by your insurance company, it is the guarantor's responsibility to pursue the insurance company on their child's behalf.

Divorce: In the case of divorce or separation, the parent authorizing treatment for child/children will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Insurance Release: This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for service rendered if any of the following conditions apply:

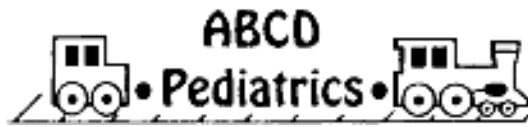
- My child/children may have a pre-existing condition or other diagnosis that may not be covered by my plan.
- Provider not participating in my health plan.
- Unmet deductible under my health plan contract.
- Well child check-up, immunizations, as well as other routine services may not be covered by some insurance plans. Please check with your insurance carrier if you are not sure if routine services are covered. (e.g. Surveys and Assessments performed during well child exams)

Outstanding Balance: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account and any payment or credits applied to your account during the month. If your account becomes past due, we will take the necessary steps to collect this debt by running your credit card on file.

ABCD understands that full payment may not be possible in certain circumstances. As a courtesy, ABCD offers a payment plan. This payment plan is a binding contract referred to as a "Payment Plan Agreement". For services to be rendered, patients with a Payment Plan Agreement must be in full compliance with all conditions of the agreement. Failure to make scheduled payments on the payment plan or not paying off a balance in full may result in your account being turned over to a collection agency.

Waiver of Confidentiality: You understand if the account is submitted to a collection agency or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

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Transfer of Records: Should you wish to transfer care to another physician, you will need to complete the authorization to release records form, which can be obtained from any of our clinic locations. This form needs to be completed in its entirety for us to process the request. All balances should be paid before records are transferred.

Billing Inquiries: Questions about a bill should be directed to our Billing Department at 210-494-2223 ext. 6855.