FINANCIAL POLICY

Responsibility
When a patient is registered with Hilliard Pediatrics, we ask that the parent or guardian seeking care accept financial responsibility for payment. This can be updated at any time by completing a new copy of this form. Parents and guardians will be held responsible for understanding their insurance coverage terms and limitations as well as payment for amounts not covered by insurance.

Payments Due at Time of Service
1. Copays are expected to be paid at time of service when applicable. There will be a $5 administrative fee assessed each time copay is not paid at the time of service. If this amount is paid in full prior to a statement being generated, this fee will be waived.
2. If you do not have insurance coverage or you are insured by a company with which we are not contracted, payment in full is expected at the time of service unless other payment arrangements are made in advance.

Secondary Insurance
It is the responsibility of the parent/guardian to inform us if they have secondary insurance. Unless we are in possession of a court document stipulating otherwise, we follow the "birthday rule" to determine which is primary. Hilliard Pediatrics will bill secondary insurances that we are contracted with once. Any remaining balances will be parent/guardian responsibility.

Professional Services Rendered
If your child is seen for a scheduled preventative visit and another condition is treated at the same time, the provider will bill for each significant and separately identifiable service performed.

Cancelled/Missed Appointments
In the event that you are unable to make an appointment, please call the office at least 2 hours prior to the scheduled time to avoid a late cancellation fee. There will be a $25 fee added to your account for all unattended appointments or late cancellations.

Balances
All outstanding balances are due within 14 days upon receipt of your financial statement from Hilliard Pediatrics. Unpaid balances that are greater than 90 days old are subject to a 3% late fee per 30 day statement cycle. Unpaid balances that are greater than 180 days old are subject to further collection activity and/or dismissal from the practice.

Payment Plans
Because we understand families may undergo financial hardship, we do offer payment plans. Your first payment will be due upon signing of the written agreement. Payment amounts will be based on amount owed. No payment plan will be given for amounts less than $100. If your payment plan is in default, the balance will be due in full. Failure to pay may result in further collection activity and dismissal from the practice.

Miscellaneous Fees
NSF-returned checks: $25 fee
Medical record copies: 1st electronic copy free, then $6.50 for additional electronic copies. Paper copies are charged per page at 50% of Ohio rate.
Forms: $10 fee payable upon receipt of form. Forms completed at the time of a well visit are at no charge.
Saturday and After Hours: $20 fee. Fee applies to Saturday appointments and any visits scheduled outside of posted hours.

Divorce, Separation, and Custody Agreements
Hilliard Pediatrics will not be party to custodial, separation or financial disputes relating to individuals with regard to minor children to whom services are provided. The responsibility for payment is with the parent or legal guardian. In cases of child custody, the parent who presents their child for care and treatment is responsible for the payment of co-pays and any outstanding balances at the time of service. Any remaining balances are the responsibility of the financial guarantor of record. We ask that you do not request the office to collect payments from a parent who is not at, or may not be aware of the appointment. Our primary responsibility is to provide medical care for your child and our providers will act in their best interest. Upon request, Hilliard Pediatrics will provide a duplicate copy of your receipt so you can seek reimbursement where appropriate.

I agree to pay for any and all medical services my child receives from this practice that my insurance company refuses to pay for whatever reason. Hilliard Pediatrics will file a claim on my behalf; however, if my insurance company refuses to pay (e.g., termination of coverage, need for clarification of benefit information, and non-covered services such as developmental screenings, vision and hearing screenings, and urine dips), I will pay for upon written/verbal notice of their refusal. I further agree and understand that this office can only code and file a claim for my child's visit with a diagnosis that was encountered and documented in the medical record. Thus, to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and considered fraudulent.

I authorize the release of any medical information necessary to process claims. I am aware that I can obtain a copy of this policy upon request. Policy is subject to change. Updates will be posted on our website at www.hilliardpeds.com.

Financial Guarantor Signature/Contact Information:

Financial Guarantor Name (*print*) ____________ Date of Birth (*mm/dd/yyyy*) ____________ Social Security Number ____________

Address / City / State / Zip ____________ Primary Phone ( ) -

Financial Guarantor Signature ____________ Today's Date ____________

Child(ren)'s Name(s): ____________

Relationship to Patient(s): ☐ Parent ☐ Legal Guardian ☐ Foster Parent ☐ Self ☐ Other: ____________