Pediatric Associates of Durango, P.C.
1199 Main Ave., Suite 205
Durango, CO 81301

Financial Policy

Thank you for choosing us as your pediatric provider. We are committed to providing you with accessible, high quality quality care with outstanding service. As some of our patients have had questions regarding patient and
insurance responsibility for services rendered, we have been advised to develop this financial policy. Please read it, ask us any questions you may have, and sign in the spaces provided. A copy will be provided to you for your records.

1. **Insurance**. We participate in most insurance plans. If you are not insured by a plan we do business with,
   payment in full is expected at each visit. **If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.** Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Self Pay.** If you are self-pay, please note that we provide a discount that can only be honored when you pay in full **at the time of services rendered**. If you prefer to pay over time with a payment plan we can not offer you this discount. Please note that this discount is not afforded to any labs we send out from the clinic and they will bill you separately.

3. **Co-Payments and Deductibles.** All co-payments and deductibles must be paid at the time of check-in
   for each visit. This arrangement is part of your contract with your insurance company and it is your responsibility to know this information. Failure on our part to collect co-payments and deductibles from our patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit. Most deductibles come due at the beginning of the year.

4. **Medicaid Patients.** All Medicaid patients must bring their current Medicaid insurance cards to EVERY visit.

5. **Parents.** If children are coming to the office without a parent/guardian, a note must be sent authorizing medical care. Labs and x-rays cannot be performed without an authorization. Be sure your child also comes with their current insurance card and their co-pay. It is the responsibility of the parent/guardian who brings the child to the appointment to pay for the bill or co-pay.

6. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurer.

7. **Proof of Insurance.** All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your current valid insurance card at every visit to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the entire bill.

8. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that if your claims are denied by your insurance company you are responsible for the entire bill. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract**. If your insurance company does not pay your claim in 60 days, the charges will automatically be billed to you.** If Pediatric Associates of Durango is reimbursed later by your insurance company and you have already paid this balance off, you will be reimbursed these monies within 1-2 weeks.

Initials

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9. **Coverage Changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

10. **Annual/Health Maintenance/Preventative Exams.** Please be aware that many insurance companies have a "maximum benefit cap" for well child visits per year. If this is your circumstance it may benefit you to get your vaccinations at the health department as they are able to discount vaccines for "underinsured" families. Some insurance companies do not cover preventive care visits at all. Due to insurance fraud issues, we cannot change the reason for your visit AFTER you have left the office. We contract with many insurance carriers, but we do not know what your specific plan covers. Our office does not make calls to your insurance company to find out what your specific plan covers. Please let us know whether you are being seen for a problem or a routine physical exam, so that we may provide you with appropriate care and avoid insurance denials. Most insurance do not cover Sports Physicals, but will cover Annual Exams. We do a thorough Annual Exam for our infants, children and teens.

11. **Nonpayment.** If your account is 60 days past due, you will receive a letter stating that you have 20 days to pay your account in full. A payment plan can be negotiated. Please be aware you will be sent to collections after your account becomes 120 days past due. In addition, you will be responsible for 27 % of the total billed amount to cover collection costs. You will be assessed a $20.00 fee plus any additional charges allowed by CRS 13-21-109 for any returned check Any payments thereafter must be made with cash or credit cards.

12. **Referrals.** It is the patient's responsibility to be in compliance with the benefits and exclusions of their insurance policy. This includes finding out whether their insurance needs preauthorization for ultrasounds, surgical procedures, D.E.X.A. scan's (bone density), medications, MRI's, CAT SCAN, etc. If you have questions, you should contact your insurance for clarification. Once you find out if any procedures do need to be preauthorized we will take responsibility to do that. If you do not notify us of this, you will be responsible for payment.

13. I understand that an outstanding balance of less than $50 must be paid off at the time of service. If the balance is more than $50 at the time of service, it will be necessary to pay towards this balance and create a payment plan. ____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines:

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Signature of Responsible Party Printed name Date
Date of Birth

Please list the names of children whom you are guarantor:

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