Shakti K. Matta MD, MS, FAAP
Pediatrics *for* You, PLLC
6802 W Rio Grande Ave, Kennewick, WA 99336
PH: 509-572-2201 FAX: 509-783-8844

FINANCIAL AND PAYMENT POLICY

Our goal is to provide and maintain a good physician-patient relationship. We wish to help you receive your maximum benefits. To achieve this, we appreciate your understanding of and assistance with our financial and payment policy. If you have any questions, do not hesitate to ask our billing office.
Most billing and payment issues can be resolved quickly and easily by clear communication and satisfactory arrangements can almost always be made. So please contact us to discuss these issues (509-572-2201).

Insurance Plans: It is your responsibility to keep us updated with your correct insurance information and to present an active insurance card at each visit. If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.
It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories. Insurance plans vary considerably, and we cannot predict or guarantee what part of the services will or will not be covered.
Health insurance is a contract between you, your employer, and your insurance company. It is important for you to be an informed consumer who understands the specifications of your insurance policy (e.g. vaccine and doctor visit coverage, referral/authorization requirements of specialty care, radiographs, laboratory tests, emergency hospital care).
You are ultimately responsible for any charges or portion thereof, for which payment is denied by insurance for whatever reason, except where prohibited by law or prior contractual agreement.

Financial Responsibility: According to your insurance plan, you are responsible for any and all co-payments, deductibles and coinsurances.
The accompanying parent or adult is responsible for full payment at the time of service. It is your responsibility to work out the payment of your child's medical care between the custodial and non custodial parent, if such circumstances exist.

Missed Appointments: We reserve the right to charge you $20 for appointments that are not canceled at least 24 hours in advance.

Co-payments are DUE AT THE TIME OF SERVICE. A $10 **service fee** will be charged in addition to your co-payment if the co-payment is not paid by the end of that business day.
You may also be required to pay your co-insurance and deductible if your annual financial responsibility with your insurance has not been met.

Outstanding Balance: for scheduled appointments, prior balances must be paid prior to the next visit unless a payment arrangement has been made with our billing office.
If you already have a payment plan with us for your outstanding balance, you must either

a. Pay in full your financial responsibility for the day before being seen for today's visit or
b. Revise the payment plan to include today's financial responsibility.

Self Pay Patients are expected to pay for services in FULL at the time of visit. If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.

Shakti K. Matta MD, MS, FAAP
Pediatrics *for* You, PLLC
6802 W Rio Grande Ave, Kennewick, WA 99336
PH: 509-572-2201 FAX: 509-783-8844

Physicals, well-child checks, attention-deficit/hyperactivity disorder checks, and the like may be rescheduled if there are outstanding balances or if a co-payment is not made at time of service. If you are experiencing financial difficulty, please let us know.

<u>Patient Balances & Rebill Fee</u> are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is DUE upon receipt of your bill.
If previous arrangements have not been made with our billing office, any account balance outstanding longer than 30 days will be charged a $10 **re-bill fee** for each 30 day cycle.

<u>Collections</u>: Any balance outstanding longer than 90 days will be forwarded to collection agency.
If your account is forwarded to a collection agency (or should your account become uncollectable due to bankruptcy), we will continue to see your child on an emergency basis for the next 30 days (as a self-pay patient), giving you time to find a new source of medical care.
You will be responsible for all costs and expenses of collection, but not limited to our reasonable attorney's fees.

<u>High Deductible Plans</u>: If you participate with a high-deductible health plan, we may require a copy of the health savings account debit or credit card, or a copy of a personal credit card to remain on file.
<u>Returned Checks</u>: A $35 fee will be charged for any checks returned for insufficient funds or declined debit or credit cards.
<u>Payment Plans</u>: If special circumstances make immediate payment impossible, payment arrangements must be approved in advance by our billing office. We offer payment plans to help you pay your responsibility.
We accept cash, checks, Visa, and MasterCard credit and debit.

<u>The Financial Agreement</u>

We must emphasize that as pediatric providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from THE DATE SERVICES ARE RENDERED. Therefore, it is necessary for you to know what benefits your insurance plan provides for you.
When you become a patient at our office, we will ask you to sign a copy of our financial policy. Prepare for your first visit by signing our financial policy in advance.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY PEDIATRICS FOR YOU. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

Name of Parent or Responsible Person: ______________________
Signature: ______________________
Date: ________________________
Children: 1. First Name:__________ Last Name:_____________
2. First Name:____________Last Name:______________
3. First Name:____________Last Name:______________
4. First Name:____________Last Name:______________