GWINNETT PEDIATRICS AND ADOLESCENT MEDICINE
FINANCIAL AND BILLING POLICIES

Our providers follow the American Academy of Pediatrics guidelines in their approach to care. We are committed to providing you with the best medical care available. The following financial policy is provided to avoid any misunderstanding and provide you with an outline of our expectations.

PLEASE NOTE: the party that brings the child to the office will be responsible for the visit's copay. The parent or the guardian bringing the child to the office will also be the responsible party on our record. We will not be involved in parental court cases. Co-Pays and deductibles are due at the time of service or the visit may be rescheduled. Whoever brings the child to the office for a visit will be authorized to receive financial and medical information.

Insurance, Billing and Patient Responsibility

Please note that there are over 1000 plans and it is ***YOUR*** responsibility to become familiar with your plan. If you do not understand your specific plan coverage, please call your insurance plan or your HR department at work. The number for your plan is listed on your insurance card.

You are expected to know if vaccines, well-checks, labs or other procedures are covered or might fall into the deductible. It is your responsibility to know if your well-check is made within the timeframe allowed by your insurance company. PLEASE REMEMBER: we are contractually obligated by your insurance company to collect your co-pay at the time of service. Your co-pay is also required at each follow up visit. If you have missed making a copayment in the past, we may ask for credit card information to be held on a secure site to be used for payment prior to making your next appointment. If you have a deductible it will be due at the time of service. Medical care not covered by your plan is due in full at the time of the visit.

As a courtesy to our patients, GPAM will bill your primary insurance company. Please remember that your insurance is a contract between you and the insurance company, not the doctor. You are responsible for balances after primary insurance has paid and payment in full is due with the receipt of the first statement. We participate in most plans, but if we do not accept your insurance you will be responsible for the day's charges at the end of the visit. Balances and/or unpaid claims over 60 days will be required to be paid in full or financial arrangements will have to be made before any future appointments will be scheduled.

*****We do not file secondary, automobile, general liability or homeowner's insurance*****

You must report ALL insurance coverage correctly. Failure to do so is considered insurance fraud. This will also result in full patient responsibility of your bill. INVALID INSURANCE INFORMATION causing the claim to be returned will be subject to a $25.00 refiling fee. Unless other arrangements are made with our financial department we refer unpaid bills to a collection company after 60 days. Unpaid balances that are transferred to the collection company may result in family dismissal from the practice. There will be a re-instatement fee of $35.00 once the balance has been paid in full.

We accept cash, check, MasterCard, Visa or Discover. There will be a $25.00 for all returned checks**. Proof of current, valid insurance MUST be provided at the time of each service.**

PAYMENT PLANS: If you are having difficulty paying your balance in full, please call our financial department for arrangements. We must have a signed payment plan and you must be paying regularly to keep your account from going to the collection agency.

CANCELLATION AND MISSED APPOINTMENTS: If it is necessary to cancel your appointment, we require that you cancel AT LEAST 24 hours prior to the appointment. Failure to cancel the appointment will result in a $50.00 fee for Well exams and ADHD visits. Sick visits will incur a $25.00 fee. As a courtesy we will call or text reminders, however, you are still responsible for the cancellation even if you did not receive a call and/or text. We reserve the right to discharge you from our practice for missing appointments frequently.

LATE APPOINTMENTS: Because of our physicians' schedules, we may ask you to reschedule if you arrive to the office more than 15 minutes past your appointment time. Late arrivals cause appointments arriving on time to be late. Continuous late arrivals may result in a discharge from the practice.

WALK IN APPOINTMENTS: Please do not bring your sick child to the office without an appointment. This can be dangerous for the child as it may delay appropriate treatment. Our nurses will triage the child for urgent problems. The doctor will review the triage notes and determine if this child can wait until an appointment can be made. We will charge the parent for the triage and review a $40.00 fee. This will be payable when you arrive at the office without an appointment. If there is an appointment available we will schedule an appointment with any provider. We will not disrupt our regularly scheduled patients in order to accommodate a walk in appointment unless it is a true emergency. Call the office and speak to our advice nurses if you feel your child needs to come to the office that same day.

AFTER HOUR CALLS: Our physicians are available on call 24 hours/day - 365 days/year for calls of a truly urgent nature. Since our practice is charged per call for after hour calls to the nurse advice line, non-urgent calls made after hours may be charged $15.00 per call.

PAYMENT RESPONSIBILITY: By signing below, the adult who signs a minor child into our practice accepts responsibility for payment. We will communicate about treatment and payment with the parent that is present. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

FOR EACH VISIT PLEASE BRING:

1. Current insurance card
2. Driver's license (don't be offended it is for your protection from identity theft)
3. Co-Pay for the day's visit (cash, check, Visa, MasterCard, Discover)
4. Deductible that may be due for the day's visit
5. Cash, Check or credit card for paying balance from previous billing.
6. Calendar for next visit

By signing below, the responsible party acknowledges that he or she has read and understood the financial policy of Gwinnett Pediatrics and Adolescent Medicine and is bound by the terms and conditions set forth therein. You also understand that failing to sign this agreement may result in discharge from the practice.

_____ _____

Signature of Parent or Responsible party (or patient >18 yrs.) Date

_____ _____

Patient Name Date of birth

_____ _____

Patient Name Date of birth

_____ _____

Patient Name Date of birth

_____ _____

Patient Name Date of birth

RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM

The Privacy Act requires that you be informed of your rights to patient privacy. In order to demonstrate that you were advised of your right to privacy of your medical records, we ask that you complete the following:

I, _____ (Legal Guardian's Name) am the responsible party for

Child's Name_____ Date of Birth_____

I am related to the child by _____ (Indicate Relationship).

Please list who **IS ALLOWED** access to your child's financial and medical history:

_____

1. Offered (but refused to read/sign) _____ (check here**) –or--,**
2. Reviewed _____, (check here), **--or--**
3. Received (for take-home)_____ (check here),

A copy of GWINNETT PEDIATRICS & ADOLESCENT MEDICINE's Notice of Privacy Practices.

Lab Results:

May we leave your child's lab results on your voicemail? Yes___ No___

If yes, what telephone number should we leave the results on?_____

Date: _____ Signature: _____

Pharmacy Name:_____ Address:_____

The American Recovery and Reinvestment Act of 2009 requires that we gather additional information from you about your background. Thank you for answering the following 3 questions:

Race:

Unknown African American Asian Caucasian Filipino Hispanic
Indian Japanese Chinese Native American Native Hawaiian
Pacific Islander Other Unknown/Decline

Ethnicity:

Hispanic Non-Hispanic Unknown/Decline

Primary Language:

English Spanish Other Unknown/Decline

How did you hear about our office?

Website Friend Ad Facebook Festival Other