Patient Name: _____ Date of Birth: _____

Capital Area Pediatrics

Financial Responsibility Policy

Capital Area Pediatrics, Inc. follows both State and Federal guidelines in billing for services rendered to our patients. This requires us to obtain specific information for each individual patient in the family; including: Consent to Treat, Insurance Assignment Authorization, Medical Release Authorization, and Individual Demographic and Insurance Information. We understand that the collection of this information can seem overwhelming, however, it is necessary in order to provide you more efficient service.

Please read carefully the information listed below. If you have any questions, our office staff will be happy to answer your questions. Questions can also be directed to our billing department at 703-359-5105 or e-mail billing@capitalareapediatrics.com.

1. The parent or guardian that presents their child for medical services is the financially responsible party. Financial responsibility for services is not based on the primary insurance subscriber.

2. If there is a financial arrangement between individual parental parties concerning financial responsibility for medical care of their children, this arrangement is between the two parties and does not absolve the parent that brings the child for services from their financial obligation to our practice.

3. The parent/guardian must provide accurate demographic and insurance information prior to patient treatment. Based on Capital Area Pediatrics' contracts with various insurance companies, we must bill for these services within a timely manner (defined by the individual contracts). If it is found that the correct information was not provided by the parent for services rendered and we miss the timely filing time limit, the patient will be responsible for the entire amount owed for services rendered.

4. A valid government ID is requested at the time of service from the person authorizing the health care services for the child designated below. Please note that if this right is being granted to a caregiver (i.e. nanny or grandparent) that is not the child's legal guardian, there must be written authorization. The written authorization must be for a specified time period, and can be revoked at any time in writing. Also, the legal guardian signing the authorization will be financially responsible for any services provided. If ID is not presented, Capital Area Pediatrics has the right to request payment in full at the time of service regardless of insurance coverage.

5. It is the parent/guardian's responsibility to know which benefits are not covered by the insurance program in which they participate, as the office staff does not have access to this information Further, the parent /guardian is fully responsible for all fees that are denied as non-covered services, deductibles, coinsurance and co-payments. If the parent/guardian has questions concerning their coverage, they should contact their employer's human resource department, their insurance agent, or their insurance company directly.

6. It is the responsibility of the parent/guardian to open and read the explanation of benefits sent to them from their insurance. If they believe there has been an error in processing their claim, they need to call the insurance company directly. Capital Area Pediatrics' billing department will be happy to assist in getting the claim resolved.

7. If uninsured or covered by an insurance plan that does not have a provider agreement with Capital Area Pediatrics, Inc., the parent / guardian is fully responsible for all fees.

8. Capital Area Pediatrics prefers that children not be seen unless they are accompanied by their parent, legal guardian, or authorized adult. However, we understand that teenagers may sometimes request services. When this happens the parent needs to let us know in advance that the child will be arriving by him/herself and authorize treatment. The parent authorizing treatment will be held financially responsible for services rendered in their absence.

9. If a minor child presents for services requesting privacy from their parent or legal guardian, this is their right based on Virginia Statute 54.1-2969. The minor will be financially responsible for services rendered, under conditions which minors are considered adults for purpose of consent. However, if the minor patient chooses, he/she may then decide to give up privacy rights and have their parents' insurance billed for the services in question. The parent will be required to contact our office to relieve the minor patient of financial responsibility.

10. Payment is expected at the time of service or in accordance with the practice's agreement with your insurance company. After an explanation of benefits from the insurance company is received, any balance that is determined to be patient responsibility is due within thirty (30) days. Should timely payments not be made, the services of an attorney and/or a collection agency may be retained. Additional collection liabilities may be assessed to the account.

11. Capital Area Pediatrics, Inc. charges a $50.00 fee for all missed appointments.

12. If a check is returned for insufficient funds, a returned check fee of $30.00 will be assessed.

13. If assistance is required in resolving a billing issue, e-mail the central billing office: billing@capitalareapediatrics.com or contact the Billing Department between 8:00am and 5:00pm Monday - Friday, 703-359-5105.

I understand by signing I have read and agreed to the policy listed above.

Patient Name (Please Print) _____ Date of Birth _____

Print Name of Parent/Guardian _____

Signature of Parent/Guardian _____ Date _____