CORNERSTONE
PEDIATRIC & ADOLESCENT MEDICINE

Financial Policy

Thank you for choosing Cornerstone Pediatric & Adolescent Medicine as your child's healthcare provider. We look forward to establishing a lasting relationship and partnership with you in caring for your child. Please take time to familiarize yourself with our office policies and feel free to ask if you have any questions or do not understand any of the policies contained herein.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best evaluation and treatment possible. Our fees reflect what is considered usual and customary for our area. You are responsible for payment regardless of the insurance company's determination of usual and customary rates.

SELF-PAY PATIENTS: Patients without insurance coverage will be required to pay for all services at the time they are rendered. A time of service discount will be offered to patients who pay in full for their visit at the time of service. We will not bill you for self-pay balances.

INSURANCE COLLECTION: Please understand that your medical insurance contract constitutes an agreement between you and your insurance carrier and not between Cornerstone Pediatric & Adolescent Medicine and the insurance company. As a courtesy, we will bill your medical insurance carrier for services we provide. We will be diligent in making sure your paperwork is filed accurately and promptly. It is your responsibility to ensure we have the most current copy of your insurance card and that your demographic and contact information is correct at the time of each visit. If we cannot verify that your insurance is active at the time of service, you will be responsible for payment at time of service. Failure of your insurance carrier to pay a claim within 45 days of the date of service will result in our office billing you directly for the balance. Should your insurance company reimburse us at a later date, we will gladly refund you.

COPAYMENTS, DEDUCTIBLES AND FEES: All copayments, coinsurance, deductibles and fees for services not covered by your insurance policy are due at the time services are rendered. Certain services (i.e. ear piercing, bili blanket rentals, nebulizer rentals, etc.) are not covered by your insurance. For any questions regarding any services/treatments, we encourage you to contact our billing department at (866) 557-2612. As a convenience, we accept all major credit cards, debit cards, checks and cash.

OUT-OF-NETWORK / NON-PARTICIPATING INSURANCE CARRIERS: If your insurance carrier considers us an "out-of- network" provider, you are responsible for payment in full at the time of service. We will gladly provide you with any paperwork necessary for you to file a claim with your carrier.

DIVORCE DECREES: This office is not a party to your divorce decree. All copayments and coinsurance are due at the time of service and are the responsibility of the accompanying adult. **We will not bill another parent/guardian for the copayments or coinsurance due at time of service.** Any balance on the account after the insurance company has processed the claim is the responsibility of the parent / legal guardian who signs the financial policy. If at any time there are legal changes to the party assuming financial responsibility for medical services received by your child due to changes in marital status or otherwise, it is your responsibility to fill out new paperwork with our office and to sign a new financial policy. **Our office will not change financial responsibility on an account or bill another party without this signed paperwork.**

NO SHOW/CANCELATION POLICY: Missed appointments represent a cost to us, to you and to other patients who could have been accommodated. Appointments missed or not canceled at least 24 hours before the appointment time will result in a $35.00 fee per 15 minute appointment block. Appointments made the same day that are subsequently missed or canceled are also subject to a fee of $35.00 per 15 minute appointment block. Appointments can only be canceled by calling during regular business hours. Phone messages and/or emails are not sufficient. Please help us serve you better by keeping your scheduled appointment.

APPOINTMENTS: In order to give the most efficient care, we work within an appointment system. We make every effort to honor all time commitments and aim to give our patients the time and attention they need while in our office. We also expect that patients extend the same courtesy to us. We ask that you arrive for your appointment at least 15 minutes in advance (for example, if your appointment is at 2:00pm, we ask that you arrive at 1:45pm). This gives us the opportunity to verify your insurance coverage, update demographics and handle any associated paperwork. **If you arrive more than ten minutes after the scheduled arrival time for your appointment, we may need to reschedule your appointment.**

Our office hours are Monday through Friday 8:30am to 5:00pm, Saturday 8:30am to 4:00pm *(by appointment only)* and Sunday 8:30am to 12:30pm *(by appointment only)*. We offer walk-in clinic hours Monday through Friday from 7:30am to 8:00am and accommodate after-hour appointments Monday through Friday from 5:15pm until 6:30pm.

Any appointment made during after hours or on weekends will incur an additional fee of $50.00. If your insurance does not cover this additional charge, you will be responsible.

TELEPHONE/FORM CHARGES: For your convenience, a triage nurse is available 24 hours a day, seven days a week. Due to the extra cost to us to provide this service, please understand that any calls to our triage service after 5:00pm Monday through Friday or anytime on Saturday or Sunday will incur a $10.00 charge. For prompt evaluation, please call early in the day during regular office hours. Please be mindful that completion of your child's forms (daycare, school, camp and sports physicals, etc.) requires time. Forms needing completion within three business days will require a $10.00 service charge per form. Payment in full is due at the time of form drop-off.

PAST DUE PAYMENTS: Just as we make every effort to accommodate you when your child is in need of medical care, we expect you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety please contact our billing office at (866) 557-2612 to discuss payment options. If your account becomes more than 60 days delinquent, your account will be subject to interest, billing fees and collection costs. Should collection action become necessary, the responsible party agrees to pay an additional 30% collection fee and all legal fees associated with the collection process, with or without suit, including attorney fees and court costs.

RETURNED CHECKS: A $25.00 fee will be charged on all returned checks.

TRANSFER OF CARE: When relocating or transferring care to another provider, we will request and require you to close out any balances due. We require a signed medical records release to process your request. Copies of your medical records are $25.00 for first child and $10.00 for each additional child. Payment is due at the time of request, and we ask for 10-14 business days to process your request.

CUSTOMER SERVICE: For questions regarding your care, services rendered or billing, please contact Intermedix, our corporate billing service at (866) 557-2612.

NOTICE REGARDING WELL CHILD CHECKS: Please be aware that it is not uncommon for patient to receive a regular check up and an evaluation of an acute or chronic illness/problem. In these cases, your insurance company may be billed for a well child exam and an additional office visit, which may require a copayment by you.

By my signature below, I authorize Cornerstone Pediatric & Adolescent Medicine to release all requested information concerning my child's medical treatment to my insurance carrier. I further authorize my insurance company to pay from the proceeds of benefits of any recovery or insurance payments in my case, directly to the provider(s) of this office for their professional services rendered.

Cornerstone Pediatric & Adolescent Medicine reserves the right to dismiss any patient from the practice who consistently fails to meet these policies or who refuses to sign this agreement.

I certify that I have read, understand and agree to the financial and office policies stated above.

_____	_____	_____
Patient's Name *(Please Print)*	Patient's Date of Birth	Today's Date

_____	_____
Signature of Patient ***(if 18 years of age)***	Parent or Legal Guardian Name *(Please Print)*

OR Signature of Parent or Legal Guardian
(if patient is under 18 years of age)