Children's Heart Institute Practice Financial Policies

1. **Patient Information/Proof of Insurance:** At each visit, all patients must complete/verify patient information before seeing the provider. We must obtain a copy of your driver's license or legal identification and current valid insurance card as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for payment of services rendered.

2. **Insurance**: We participate in most insurance plans. If you are not insured by a plan with which we are contracted, payment in full is expected at each visit. If we are a participating provider with your plan, but do not 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 and rules is your responsibility. Please contact your insurance plan with any questions you may have regarding your coverage.

3. **Referrals:** Your insurance may require a referral form from your primary care physician for procedure/service(s) prior to your visit. It is the patient's or guarantor's responsibility to obtain the appropriate referrals prior to your office visit. If you are unable to produce a referral at the time of your visit, you will be given the option to reschedule the visit or sign a waiver of insurance and pay for the visit in full.

4. **Co-payments and deductibles:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Deductibles are due at the time of notification by your insurance company.

5. **Non-covered services**: Not all services provided by our practice are covered by every plan. Any service determined to not be covered by your plan will be your responsibility, Please be aware that some of the services you receive may be determined to be non-covered or not considered reasonable or necessary based on the benefits of your specific plan. You will be financially responsible for the cost of services that are not paid. The charges for these non-covered services be your responsibility and must be paid before being scheduled for another appointment.

6. **Coverage changes:** If your insurance changes, please notify us before your next visit to help you receive your maximum benefits. Failure to notify us of insurance changes could result in denial of claims and patient responsibility for payment of the denied claim.

7. **Claims submission:** Your insurance benefit is a contract between you and your insurance company. We will submit your claims for the services which have been provided. Your insurance company may need you to supply certain information directly in order to process a claim. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

8. **Nonpayment/delinquent accounts:** If the patient responsibility portion of your account is over 60 days past due, you will receive a letter stating that you have 10 days to pay your account in full to halt collection

activity. In the event your account becomes delinquent, you will be liable for all reasonable collection/attorney fees plus filing and processing costs.

9. **Missed appointments:** Our policy is to charge for missed appointments not canceled within 48 hours of your scheduled appointment. These charges will be your responsibility and must be paid before being scheduled for another appointment. The charge for missed appointments for patients with POTS is $100, for all other conditions it is $50.

10. **Forms Fees:** Any forms such as school, camp, sports, family and medical forms are subject to a fee that is due when the forms are dropped off. Completing these forms is time consuming to our staff, and requires time away from patient care from our providers. The charge for the form is determined by the complexity of the required written or verbal communication. Fee amount may periodically change without prior notice. Payment for these forms is nonrefundable. It is our duty that these forms are accurate and consistent with the patient care plan needs. We require 15-days turnaround time.

11. **Release of medical information**: You will be provided a copy of our policies at the time of your visit and required to sign a release that authorizes us to provide a copy of your medical records if requested by your insurance carrier to process a claim. This release will expire one year from the date of your signature unless cancelled in writing prior to that date.

12. **Contacting us concerning your Bill:** You may call our Billing director at 571-612-2600 or you may email us at billing@chiva.org with any billing questions or concerns. Our goal is to provide and maintain a good Physician-patient relationship focused on your clinical needs while letting the experts in our billing department handle their work directly. Please address all billing concerns with those experts rather than your physician so that your clinical team can focus on your medical care.

13. **Termination of Services:** If you do not respond to 3 notices to the address we have on file, you agree that Children's Heart Institute PLC may terminate your relationship with all of its offices. You will be considered an active patient as long as your account is in good standing and we provide you services within a 3 year period. You will have deemed yourself as terminating our relationship if you have no contact with us for this period of time. Acceptance back into the practice as a new patient is at the discretion of the individual our provider.

14. **Overdue Accounts:** Overdue balances will be sent to the collection company after 90 days. In the event the balance is sent to the collection company, a 30% collection fee will be added on top of the balance.

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name(s)_____

Responsible Party Member's Name_____ Relationship_____

Responsible Party Member's Signature _____Date _____