FINANCIAL POLICIES AND PROCEDURES

Welcome to our practice! We are committed to providing you with the best possible care to your children. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy. Even though we do not file secondary or supplemental insurance, if you need assistance, we will be happy to accommodate you. If you have any questions, feel free to contact one our account managers for assistance. They may be reached by calling 972-331-7200 option #6.

As of June 1, 2007, this office participates with the following insurance plans:

Aetna US Healthcare HMO, PPO, EOP, POS
Beech Street
Blue Cross Blue Shield
Cigna HMO, PPO, POS
Great West
Unicare Classic and Performance
Healthsmart
HMO Blue
Private HealthCare Systems (PHCS)
North Texas
United Healthcare

There are a number of unique individual place we will file but it is your responsibility to know your healthcare benefits. The above list is subject to change, so please ask one of our front office experts for clarification.

<u>At the time of service, you will be responsible for all deductible, co-insurance, and co-payments amounts.</u>

<u>Reminder:</u> Please remember to bring your insurance card to your visit so that we may obtain a copy.

<u>Cancellation Policy</u>: If you know in advance that you will be unable to keep a scheduled appointment, please call 24 hours in advance so that we may use this time for other children in need of checkups or who are acutely ill. Cancellations less than 24 hours in advance of this visit may be billed in full to the patient, unless we are notified in advance of reasonable circumstances, beyond your control, that keep you from coming at the scheduled appointment time. If you anticipate being late for an appointment, please call so that we can make arrangements to change our scheduling, if possible.

If we do not have a contract with your insurance carrier, payment for services is due at the time services are rendered. Should you need assistance with the management of your account, arrangements must be made in advance. Our Account Managers will be happy to assist you. We accept cash, checks, credit and debit cards (MasterCard, Visa and Discover).

If there is an overpayment on your account that results in a credit, we will notify you via telephone and/or US Postal Service. If you fail to respond within 120 days, a processing fee may be assessed. Refund checks issued by Clinical Pediatric Associates of North Texas (CPANT) that are not redeemed within 90 days may be subject to a $35.00 processing fee. Please make sure that we have current contact information on your account to avoid assessment of these fees.

We will gladly answer any questions relating to your insurance. You must realize however that:

- Your insurance is a contract between you, your employer, and the insurance company. We are often not a party to that contract.
- All insurance benefits are determined by the employer and contracted with the insurance company. We have no control over your benefits.
- As a courtesy to our patients, we put forth all efforts to verify your benefits prior to an appointment, but please be aware it is your responsibility to know your benefits if we are unable to do so in advance.
- Not all services are a covered benefit in all contracts. Some insurance companies and/or employers select services they will not cover.
- Processing fees may be applicable for related services provided. Re-issuing checks, stop payments, or outstanding balances over 30 days may result in such fees. Please discuss with a manager if you have any questions.

Our practice is committed to providing the best treatment for our patients, and we charge what is appropriate based on geographic location, physician skill and expertise. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. It is your responsibility to submit any non-participating claims to their carrier, and we will provide you with any necessary information for proper processing Extensive documentation requirements may result in processing fees. Please discuss the assessment of your options with a manager prior to processing.

We must emphasize that as a medical care provider, 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 your responsibility from the date services are rendered. Should any financial issues affect timely payment on your account, please contact us promptly for assistance in the management of your account.

Return checks are subject to an additional collection fee of $35.00. Personal balances older than 30 days may be subject to an additional $10.00/month administrative charge unless prior arrangements are made. In the event that your account is sent to collections, you agree to pay all related costs and expenses, including attorney's fees.

If you have any questions about the above information, or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to assist you. We also advise you to keep a copy of these forms for your own personal records. Thank you for your time in carefully reviewing our financial policy.

I have carefully read the above office policy, as well as understanding and agreeing to the terms and conditions of such.

Patient Name (Please print) ______________________________

Parent/Legal Guardian SIGNATURE ______________________________ Date ____________

We would like to thank you for choosing our physicians as your families' partner in providing excellent and loving health care to your children from birth through adolescence.

FINANCIAL AGREEMENT

I have received a copy of the financial policy of Clinical Pediatric Associates of North Texas (CPANT) and in consideration of the patient receiving services from CPANT, I understand and agree that:

- I am responsible for all expenses treating the named patient/patients.
- Payment of charges is due at the time of the appointment.
- If CPANT files insurance on my dependents behalf, I agree to pay for non-covered services, co-insurance, co-pays and deductibles.

____
Patient(s) Name

____
Responsible Party's Signature (Parent/Guardian)

____
Date

AUTHORIZATION TO RELEASE INFORMATION AND TO PAY BENEFITS

I authorize Clinical Pediatric Associates of North Texas (CPANT) to release any of my medical information to my insurance company(s) as needed to process my insurance claims.

I authorize my insurance company to make payments directly to Clinical Pediatric Associates of North Texas (CPANT) for covered medical and/or surgical services.

____
Patient(s) Name PRINTED NAME

____
Responsible Party's SIGNATURE (Parent/Guardian)

____
Date