Mid-Ohio Pediatrics and Adolescents, Inc.
465 N. Cleveland Ave. Suite 200
Westerville, OH 43082
(614)899-0000 (614)899-0524 Fax

# Financial and Patient Responsibility Policy

The Physicians and staff at Mid-Ohio Pediatrics and Adolescents, Inc. are committed to providing you with the best possible medical care. We make every effort to keep our fees reasonable while at the same time covering the cost of the services we provide. The following information is to avoid any misunderstandings or disagreements concerning payment for professional services.

As physicians, our relationship is with you and your child, not your insurance company. If you have health insurance that we contract with, we will file your insurance claims as a courtesy to our patients. However, all charges are ultimately your responsibility. **Failure to disclose all current and accurate insurance coverage may result in dismissal from our practice.**

Our office participates with a variety of insurance plans. It is your responsibility to:

- O Present ALL current insurance cards at every visit, including Medicaid or State funded insurance if applicable as MOP has a timely filing limit set by your insurance company to submit claims.
- O Pay the co-pay at every visit. Both Ohio state law and your insurance company require your co-pay to be paid at the time of service.
- O Know the coverage and limits of your insurance policy. It is important for you to know what services are covered benefits in your individual policy as we are not able to know what each policy will cover.
- O We send all labs and x-rays to Nationwide Children's Hospital facilities. It is your responsibility to let us know if another facility is preferred by your insurance.

Co-pays and outstanding balances are due at the time of service

Please remember that your plan coverage and associated costs are determined by your insurance company, not Mid-Ohio Pediatrics and Adolescents, Inc. According to your specific health insurance policy, you are responsible for any and all costs that are determined by your insurance plan and reported to us on an explanation of benefits (EOB). Your MOP monthly statement will reflect this cost and your balance which may include co-pays, deductibles and coinsurances. The exception to this are HSA, HRA, and high deductible plans as these type of plans will require payment of their deductibles at the time of service.

**If we are not contracted with your insurance company, cannot verify your insurance coverage, or you do not have insurance, payment in full is due at the time of service.**

When significant conditions are uncovered or addressed at a well child exam, an additional charge may be incurred.

Examples include but are not limited to; asthma, ADHD, behavioral concerns, developmental and speech delays, growth problems including overweight and obesity, headaches, abdominal pain, ear infections or upper respiratory infections. These conditions are not included as part of preventive medicine services but are often critical to the health of your child and must be addressed at the well child exam, even if you do not have concerns about the condition. **We follow the American Medical Association's standard of billing and coding guidelines when charging for our services.**

Mid-Ohio Pediatrics and Adolescents, Inc.
465 N. Cleveland Ave. Suite 200
Westerville, OH 43082
(614)899-0000 (614)899-0524 Fax

Newborns

It is your responsibility to contact your insurance company to add your newborn to your policy. Failure to contact your insurance company will result in your child not having health care coverage and you will be financially responsible for all medical services. Please provide Mid-Ohio Pediatrics and Adolescents, Inc. with your child's health care coverage information immediately upon receipt and within 28 days of birth to assure timely billing.

Parent/Guardian Financial Responsibility

Mid-Ohio Pediatrics and Adolescents, Inc. will not become involved between parents, guardians, attorney or court orders with regards to financial responsibility. Payment issues between any of the parties must be resolved prior to services being rendered as payment is due at the time of service from the parent/guardian requesting medical services. Monthly statements are mailed to one address only. Services that remain unpaid will be reported under both parents/guardians for collection purposes.

Unpaid Balances

**All patient balances billed are due within 30 days of the statement date.** Any patient balance that has not been addressed within 30 days of the statement date will be considered delinquent. We realize temporary financial circumstances may affect timely payment on your account so we will be happy to work out a payment arrangement. If you are unable to make mutually agreeable payment arrangements, we will be glad to reschedule your appointment at a time when you will be able to pay. If the account remains unpaid or payment arrangements are not upheld, your account will then be placed in dismissal status. Once an account goes into dismissal status, sick care will be provided for 30 days, if needed. After these 30 days, no further care will be provided and your family will be dismissed from the practice. If you have any questions or concerns, please contact our billing department for assistance at (614) 899-0000.

Miscellaneous Charges

**Return Check Fee** - Non Sufficient Funds (NSF) checks are subject to a $35.00 fee (in addition to fees from your bank). After two NSF checks, we will no longer accept checks as a form of payment on your account.

**Medical Records Charge** – According to Ohio Revised Code, there is a per page fee for records. This fee will depend on the number of copies requested and other reasons as specified in ORC 3701.741 at codes.ohio.gov/ORC. Once we receive a signed records request form, one of our staff members will contact you with the amount due. Records will not be released until payment is received.

**No Show/Cancelation Policy** – Any same day ill appointment not cancelled at least two hours in advance, all other appointments with less than 24 hours' notice or not showing for an appointment will result in a $35.00 charge. Arriving more than 15 minutes late for an appointment will be considered a No Show and will be rescheduled for another day or time. Reminder calls or texts are a courtesy, not a guarantee. Failure to receive a reminder call or text is not an excuse for removing the $35.00 charge.

Mid-Ohio Pediatrics and Adolescents, Inc.
465 N. Cleveland Ave. Suite 200
Westerville, OH 43082
(614)899-0000 (614)899-0524 Fax

## Authorizations Acknowledgement

I authorize the physicians and staff of Mid-Ohio Pediatrics and Adolescents, Inc. to provide any medical care deemed necessary according to their professional opinion.

Initials_____

I authorize the release of any and all medical information necessary for claim submission or payment of services from the insurance carriers or other payers to who claims have been or are being submitted. I authorize my insurance benefits to be paid directly to Mid-Ohio Pediatrics and Adolescents, Inc. for any services furnished to me or my child by the associated physicians. I understand and certify I am financially responsible for all health care service charges that are paid to me directly or by my insurance carrier as well as any applicable co-payments, co-insurance, deductibles and/or charges for non-covered services provided to my child/dependents.

Initials_____

I have had an opportunity to read or receive a copy of Mid-Ohio Pediatrics and Adolescents, Inc.'s Notice of Privacy Practices.

Initials_____

I have received a copy of Mid-Ohio Pediatrics and Adolescents, Inc.'s Financial and Patient Responsibility Policy.

Initials_____

## Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Mid-Ohio Pediatrics and Adolescents, Inc. to use and disclose my protected health information (PHI) to carry out treatment, payment and healthcare operations. I understand that Mid-Ohio Pediatrics and Adolescents, Inc. may share my PHI with other health professionals, in the course of healthcare treatment. I understand that my protected health information may be released as the physicians and staff of Mid-Ohio Pediatrics and Adolescents, Inc. determines appropriate in an emergency situation.

I consent to the use of my medical information necessary for transmission of prescriptions to the pharmacy and as needed for the coordination of formulary and/or benefits eligibility with my insurance provider. I consent to the query of my external prescription history as necessary to manage my healthcare and related services.

I consent to the use of phone numbers, voice mail, text messaging and addresses provided as forms of contact in reference to any items that assist the practice in carrying out, appointment reminders, billing, and clinical care or laboratory results. (If text messaging is chosen as a form of contact, any fee associated to the text is the patient's responsibility.)

I acknowledge it is my responsibility to provide Mid-Ohio Pediatrics and Adolescents, Inc. with the most current and up to date and accurate insurance information, patient contact phone numbers and address.

Initials_____

_____ _____ _____

Patients First Name Patients Last Name Date of Birth

_____ _____

Printed Name of Patient/Parent/Legal Guardian Initials

_____ _____

Signature of Patient/Parent/Legal Guardian Date