Aloha Pediatrics LLC Financial Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our policy allows for a good flow of communication and enables us to achieve our goal. Please read this carefully and if you have any questions, please do not hesitate to ask a member of our staff.

1. On arrival, please check in at the front desk and present your current insurance card AT EVERY VISIT. You will be asked to sign and date the file copy of the card. This is your verification of the correct insurance and consent to bill them on your or your child's behalf. IF THE INSURANCE COMPANY THAT YOU DESIGNATE IS INCORRECT, YOU WILL BE RESPONSIBLE FOR PAYMENT OF THE VISIT AND TO SUBMIT THE CHARGES TO THE CORRECT PLAN.
2. If we are your primary care physician (PCP), make sure our name and phone number appear on your card, if applicable. **If your insurance company has not been informed that we are your PCP as of this date, you may be financially responsible for the visit.**
3. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances.
4. Your insurance policy is a contract between you and your insurance carrier and it is your responsibility to understand your benefit plan. It is your responsibility to know if a written referral or authorization is required to see specialists, if preauthorization is required prior to a procedure, and what services are covered. Medicaid/Quest Integration patients need to understand that these plans require frequent updating on your part. Your failure to update the policy as required could make you responsible for charges for services rendered.
5. If our physician does not participate in your insurance plan, payment in full is expected from you at the time of your office visit. For scheduled appointments, prior balances must be paid PRIOR TO THE VISIT.
6. If you have no insurance, payment for an office visit is to be paid at the time of the visit. A 20% discount will be given for services paid at the time of the visit.
7. **Co-payments are due at the time of service.** This co-payment is a contractual agreement between you and your insurance company. We are REQUIRED to collect your copay. A $10 service fee will be charged in addition to your co-payment if the co-payment is not paid at the time of service or by the end of the following business day.
8. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
9. If previous arrangements have not been made with our financial office, any account balance outstanding greater than 28 days will be charged a $10 re-bill fee. Any balance over 60 days will be forwarded to a collection agency which will result in an additional processing fee.
10. If you participate with a high-deductible health plan, we require that a copy of the health savings account debit/credit card or a personal credit card remain on file.
11. We require 24-hour notice for cancelling any appointments. There is a $25 no-show fee if they are not cancelled with 24 hours' notice.
12. A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

13. We charge a $10 fee per child to copy or transfer medical records. This is to cover the staff time and materials.
14. If your child has school, camp, or sports physical forms to be completed, there is a $15 charge per form if the form is not presented at the time of the physical. Payment of this fee is required when the form is dropped off. There is a 3-5 day turnaround time for these forms. This fee is charged to cover physician time required to complete the form outside of an appointment time.
15. There is a $25 charge for the completion of FMLA forms and a 5-7 day turnaround time. This charge is to cover the extended physician time to complete these forms. The fee is due at the time the form is dropped off.
16. Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. Not all plans cover annual physicals or hearing and vision screenings. It is your responsibility to know your insurance plan benefits. If it is not covered, you will be responsible for payment at the time of visit.
17. Not all services provided by our office are covered by every plan. Any service determined to not be covered by your plan will be your responsibility.
18. Aloha Pediatrics LLC will hold the parent/guardian whose signature is on this form financially responsible for all charges incurred, regardless of divorce decree or child support order as stated by Hawaii Law.

I have read and understand this office financial 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:_____