FINANCIAL POLICY (2016)

We at Little Star Pediatric Urgent Care (LSPUC) are committed to providing you with quality care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about this financial policy.

TO assist us in establishing your LSPUC financial account, please:

- Supply all necessary information for the accurate billing of your claim, including your insurance card, employer information and demographic information.
- Satisfy all insurance co-payments, deductibles and non-covered services on the day services are rendered.
- Provide your insurance company and LSPUC with any additional information requested to complete the processing of claims filed on your behalf.

UNACCOMPANIED MINORS
Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:
LSPUC does not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

REGARDING INSURANCE
Indemnity/Fee for Service: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing.

Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered charges, co-insurance, secondary insurance, coordination of benefits, pre-existing conditions, or "reasonable and customary" charges other than to supply the factual information as necessary. You are responsible for timely payment of your account.

CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)
For each visit to LSPUC, it is your responsibility to make sure he/she is currently under contract with your managed care plan. Verification of your coverage and benefits may be required. Often this verification requires us to share the reason for your visit with your managed care plan. Please plan to show your current card at each visit.

If you are referred to a specialist or decide you need a specialist, you may be required by your managed care plan to call your Primary Care Physician in order to obtain an insurance referral. It is your responsibility to keep track of the expiration dates and for giving your doctor's office a minimum of 48-hours notice before being seen by a specialist. Retro referrals may not be allowed on all managed care plans. Therefore, if a referral is not obtained, you may be held responsible for payment in full by the Specialist.

- As a service to our Patients, LSPUC provides courtesy appointment reminders calls/texts and possibly other important calls that may be placed using a pre-recorded auto-message system. Your initials confirm your consent to receiving such calls/texts at the telephone number provided to us. _____
- I have read and understand that I am personally responsible for payment on this account.
- In the event my insurance company deems a service to be "non-covered" I understand that I am personally responsible for payment.
- **Medicaid: I do _____ do not _____ currently have Medicaid insurance (Please Initial Response)** _____
- Assignment: I hereby authorize payment directly to LSPUC or my Physician. Any changes in this authorization must be received in writing within 30 days of the effective date.
- I agree to the release of any and all medical information, including HIV test results, and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release.

Any changes to this authorization must be received in writing within thirty days of effective date.

Guarantor Signature: _____ **Date:** _____

Print Name: _____ Guarantor Date of Birth: _____

Relationship to Patient: _____

PATIENT(S) NAME: _____ Date of Birth: _____