Financial Policy – (Updated 1/ 2022)

The following information is provided to Avoid any Misunderstanding or Disagreement Concerning Payment for Professional Services.
We will file to the insurance as a **COURTESY**; however, **YOU** are ultimately responsible for your child's Charges.

1. Our office participates with a variety of Insurance plans. It is **YOUR** responsibility to:
    - Bring your Health Insurance Card and Photo I.D. at Every visit.
    - Pay your Co-Payment and any Deductibles at Each Visit. Payment can be made by cash or credit card.
    - We accept VISA, MasterCard, American Express and Discover. In compliance with our contract with your insurance carrier, Pediatric Pod CANNOT discount/waive any copay/deductible/coinsurance amounts.
    - Payment in full at the time of service for any medical care or services that are not covered by your insurance plan.
2. If your child has Insurance that we do not participate with, or your child does not have Insurance, Payment in Full is expected at the time of service. Your child will be a "Self Pay" patient in our office.
3. If your Insurance plan is an HMO or POS policy it may require you to choose a PCP (Primary Care Provider). You will need to choose a physician from our practice before your appointment. If your insurance card lists another physician's name, we can see your child, but you will be "Self Pay" until the PCP has been changed to one of our physicians.
4. Proof of insurance is not a guarantee of coverage or of payment.
5. We **do not** file secondary insurance. You may request a copy of the claim to file yourself.
6. You are financially responsible for any amount not covered by your child's health insurance plan.
7. You are financially responsible for all charges incurred in your child's care and treatment.
8. If you have questions about your insurance, we can help where possible. However, specific coverage issues should be directed to your insurance company members services department. The telephone number is usually located on your insurance card. In the event that payment is erroneously denied by the insurance carrier, it is your responsibility to pursue action with the insurance carrier, as the policy is a legal contract between the patient and the insurance carrier.
9. If you **fail to make payment in full** for services that are rendered to you, your outstanding balance will be sent to an outside **collection agency**. Accounts are considered past due after 90 days. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.
10. To protect your child's records, we ask you to provide our office with a driver's license or other picture ID. Annually, or as changes occur, we will ask you to sign our financial policy and update your registration information. We will scan your insurance card and ID into your child's electronic medical chart. We will check these documents prior to releasing your child's records.
11. In cases of divorce and/or separation, the legal guardian and/or the person bringing the child in for services will be held responsible for paying any balance originating from that visit. If you provide legal documentation that someone other than the legal guardian is financially responsible and you provide billing information for that responsible party, we will attempt to bill that party. However, if the balance is unpaid by that person, you will be held responsible for the balance on your child's account.
12. Payments will be requested by and returned to **AIDA KHANUM MD, MPH, PLLC as Pediatric Pod** does business under this Corporation.
13. For **Payments Call: 713-669-1900**
14. For **Billing Questions call: Erica/Leslie – 832-364-6824 or 713-429-4374**

Late Arrival/No Show Policy: Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule to another day or may be worked back into the schedule/moved to the end of the day. If you cannot keep your appointment, we ask you to cancel at least **24 hours prior** to the appointment time. If you **"no show" three times** we reserve the right to **discharge** your child from the practice. Appointments that are missed or not cancelled 24 hours prior to the scheduled appointment time will be charged a NoShow fee of **$25.00**.

Advanced Beneficiary Notice: These services may NOT be covered by your insurance carrier. The purpose of this list is to help you make an informed choice about whether or not you choose for your child to receive certain services. The fact that your insurance carrier does not cover a service does not mean that you should not receive that service, it just means that you have a choice as to whether your child receives it or not. If you choose to receive one of these services in the office and it is later denied by your insurance carrier, you will be financially responsible for the balance on your account.

Service:	CPT Code
Pure Tone Screening Auditory Test (hearing test)	92551
Screening of visual test acuity (vision test)	99173
Fluoride varnish	99188/99429
Developmental Testing	96110
Preventive Medicine Risk Management (counseling for delayed vaccine schedule)	99401/99402
30 Month Checkup (AAP recommended)	99392/99382

Additional Fees:

- Forms requiring more than a signature: $10 per form, $25 if needed in less than 72 hours
- Collections Fee: Additional Financial charge of 30% of the amount due if your account is sent to collections
- Medical Records not released to another physician: $25 and up per chart for printed copies, $10 for electronic copies

We will not be able to provide medical care to children whose Parents/Guarantors refuse to sign and comply with our financial policy.

Signature of Understanding:
I have received a copy of the Pediatric Pod financial policy, which I have read and understood. I 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.

Child's Name	Date of Birth	Child's Name	Date of Birth
Child's Name	Date of Birth	Child's Name	Date of Birth

Patient or Parent/Guardian if Patient is under 18 years of age Date

ASSIGNMENT OF BENEFITS

I, the undersigned authorize payment of medical benefits to PEDIATIRIC POD for any services furnished to my child by the practice. I also authorize you to release to my child's insurance company or their agent, information concerning health care, advice, treatment, or supplies provided to my child. This information will be used for the purpose of evaluating and administering claims of benefits. This assignment shall remain valid until written notice is given by me.

Patient (if 18 or older) Parent/Guardian (if Patient is under 18 years of age) Da**te**