PEDIATRIC ORTHOPEDIC ASSOCIATES OF SAN ANTONIO
PATIENT FINANCIAL POLICY

Identification

The parent or legal guardian must provide picture identification and Social Security Number. A legal guardian other than a parent must also provide proof of guardianship. We must be sure the person bringing in your child has a right to do so. This is to help ensure the safety of your child.

Referrals

If your insurance has designated a primary care physician (PCP), you are required to have a referral to us from your PCP prior to your visit with us. Your insurance company may require a "Prior Authorization", as well. If this authorization is not provided, you will be asked either to reschedule your appointment or to pay for your visit at the time of service. Without the referral, insurance cannot be billed.

Co-Payment, Deductible, Co-insurance Payments

The patient is expected to present an insurance card at each visit. All insurance-required co-payment, deductible, and co-insurance amounts, as well as past due balances, are due and payable at the time of service.

Self-Pay Accounts

Self-pay accounts are (1) patients who are covered by insurance plans with whom this practice is not contracted at time of service, (2) patients without an insurance card on file at the time of service, or (3) patients who have not met the insurance plan deductible. Payment is due at time of service - for clinic visits and for surgeries.

Discounts

For patients who pay in full at the time of service, and for whom we do not need to invoice an insurance company, we offer a ten per cent (10%) discount.

Non-Covered Items

Some insurance plans consider certain cast and other supplies non-covered. Payment for such items is then guarantor responsibility.

No-Show Charge

We will bill you $50 for failing to appear for your appointment and failing to give us 24-hour notice of your inability to do so. If you give us sufficient notice, we may be able to reschedule another patient into that appointment time, and you will not be charged the fee.

Non-participating (Not Contracted) Insurance Plans

While we are contracted with most insurance plans, it is not possible for us to be contracted with ALL of them. If we are not contracted with your insurance plan, we will look to you for payment. See "Self-Pay Accounts" above. However, as a courtesy to you, once you have paid our fees, we will invoice your insurance company for you, upon your request. Sometimes there may be a fee to invoice a non-contracted insurance company. Your insurance company will send payment directly to you. If we are mistakenly paid (it has happened), we will forward the payment to you promptly.

Automobile Accident Cases and School Accident Insurance

The patient will be treated as a Self-Pay account.

Patient Refunds

Overpayments will be refunded within 30 days, when there are no outstanding insurance claims or unpaid patient balances on the account.

Divorce Cases

The person who accompanies a child to our clinic is responsible for payment. This includes co-pays, co-insurance, and non-participating insurance balances. We cannot bill a (non-accompanying) divorced spouse (or his / her insurance company) for the patient's services.

Child Custody Cases

The parent with primary custody is usually the parent with whom the child lives and who usually brings the child to the clinic for care. The custodial parent is responsible for payment at the time of service whether the account is considered self-pay, participating insurance, or non-participating insurance. If the non-custodial parent carries the insurance on the child, we will bill that insurance company. We cannot get involved in custody specifics, e.g., one parent pays 80% and the other pays 20%, as we are not a party to the court agreement. It is the parents' obligation to work out an arrangement themselves or through the court system.

Past Due Balances & Returned Checks

Balances older than 30 days will be assessed interest at current legal rates. NSF checks will be assessed a $35 fee. Accounts sent to an attorney (or collection agency) for collection will be assessed a 40% collection fee. Your Credit Report WILL BE AFFECTED. DO NOT fall behind in your payments.

This financial policy helps us provide quality care to our valued patients. If you have any questions or need clarification of any of our policies, please feel free to contact us at (210) 692-1613.

I understand and agree to all of the above.

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Printed Name

______________________________________ ________________________
Parent Signature Date