

**Pediatrics of Arlington, PLC**  
1635 N George Mason Suite 185  
Arlington, VA 22205

## **FINANCIAL AND ADMINISTRATIVE POLICY**

Effective 5/1/2022

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policies allows for a better flow of communication and enables us to achieve our goal. Please read each section carefully and sign initials where designated. If you have questions, do not hesitate to ask a member of our staff.

### **Insurance Plans/Copayments/Deductibles**

- 1) It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
- 2) It is your responsibility to understand your benefit plan including, but not limited to: copay amount, deductible amount, covered services, need for written referrals, or preauthorization. We are here to assist you in any way, but every policy is unique.
- 3) According to your insurance plan, you are responsible for any and all copayments and deductibles.
- 4) **Copayments and outstanding balances** are due at the time of service. A **\$5 service fee** will be charged in addition to your copayment if the copayment is not paid by the end of that business day.
- 5) Self-pay patients are expected to pay for services in FULL at the time of the visit.
- 6) If we do not participate in your insurance plan, payment in full is expected at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- 7) Patient balances are billed immediately on receipt of your insurance plan's explanation of benefit. Your remittance is due within 10 business days of your receipt of your bill.
- 8) If previous arrangements have *not* been made with our billing office, any account balance outstanding longer than 30 days will be charged a **\$25 re-bill fee** for each 30-day cycle. Any balance longer than 90 days will be forwarded to a collection company.
- 9) In order to collect copayments, form fees, or your portion of the bill once the insurance company processes your claim, you may keep a **credit card on file**. The credit card will be linked to your account. We have a scanner that can securely encrypt and store your credit card information. Pediatrics of Arlington, PLC, will only charge your card with your consent the outstanding amount that your insurance company determines to be 'patient responsibility'.
- 10) Payment may be received in the form of a personal check. A **\$50** fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

- 11) Please contact your insurance company to add your newborn to your insurance policy. Most policies require the newborn to be added to the insurance policy by one month of age in order for services to be paid from the date of birth. Failure to do so may result in a personal balance that is the financial responsibility of the assigned account holder.

Initial: \_\_\_\_\_

### Appointments

- 1) We value the time we have set aside to see and treat your child. There is a **\$50 fee for missed well child appointments** and a **\$25 fee for missed acute care appointments**. There will be a **\$10 fee for missed vaccination appointments**.
- 2) If you are more than 15 minutes late for your well child appointment, we will do our best to accommodate you; however, on certain days, it may be necessary to reschedule your appointment. **Late arrivals that cannot be accommodated are considered missed appointments and will be charged a no-show fee (\$50)**.
- 3) Before making an annual physical appointment, check with your insurance company whether the visit will be covered as a healthy visit. In particular, some insurers will not cover annual visits spaced less than 12 months apart. Not all plans cover well physicals or hearing, vision or mental health screening. **Any service not covered by your insurance plan will be your responsibility**.
- 4) Many insurances cover well/preventative care visits. However, if new medical diagnoses are discussed or changes in management of chronic conditions occur, there may be an office visit charge in addition to your well exam charge. Copays will be applied, per your insurance plan.
- 4) Sports pre-participation physicals that are needed in addition to an annual well child visit will usually not be covered by insurance. A self-pay fee of \$75 will be due at the time of the visit and will include completion of the Sports Pre-participation Physical form.

Initial: \_\_\_\_\_

### Triage

Telephone calls overnight from 10PM to 8AM will be answered initially by a nurse triage company. There will be a **\$25 fee** to cover the cost of this service.

Initial: \_\_\_\_\_

### Forms/Letters

- 1) If your child has school, allergy, camp or sports physical forms to be completed, please let the front desk know at the time of check-in. There is a **\$25 charge per form**. Payment is due when the forms are dropped off.
- 2) Please expect a 3-5 day turnaround unless the forms are done at the time of a well visit. If a form is needed sooner than 3 days, there will be an additional **rush fee of \$15**.
- 3) If a Letter of Medical Necessity is requested, we ask that the parent or legal guardian submit a written example of the letter (including the title, name and address to whom the letter is intended). Once the letter is reviewed, it is up to the provider's discretion to generate and sign the letter. There will be a minimum charge of \$25.

Initial: \_\_\_\_\_

**Transfer of Records**

- 1) We charge an administrative fee of **\$25 per child** to copy or transfer medical records. These charges must be paid in full before the records will be available for transfer/pick up.
- 2) Please allow 7 business days for completion. If a form is needed sooner than 7 business days, there will be a **\$25 rush fee.** Initial: \_\_\_\_\_

**Laboratory Fee**

- 1) In order to cover the laboratory operating costs and maintain our high quality of care, a **convenience fee of \$35** will be charged to have your child's blood specimen drawn by our lab technician on site. This fee is not covered by insurance.
- 2) You have the option to go to Virginia Hospital Center or another laboratory that contracts with your insurance company. Initial: \_\_\_\_\_

**Prescription Refills**

Please request a medication refill **at least 3 business days** before you run out of your child's medicine. This allows the responsible prescribing physician to verify that your current prescription is appropriate and refilled properly.

Initial: \_\_\_\_\_

**I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.  
Fees are subject to change.**

Patient Name _____	Date of Birth _____
Patient Name _____	Date of Birth _____
Patient Name _____	Date of Birth _____
Patient Name _____	Date of Birth _____

Responsible Party Member's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party Member's Signature \_\_\_\_\_ Date \_\_\_\_\_