Financial Policy
Pediatrics Associates of the Northwest

The primary goal of our practice is to provide the finest pediatric care to the children and young adults in our community. Since our practice has obligations that must be met, we ask that you agree to abide by our payment policies. Insurance coverage is an agreement between you and your insurance company for the payment of medical services. You are responsible for understanding your coverage benefits and guidelines for obtaining medical services. You are ultimately responsible for full payment of professional services, laboratory charges or associated costs incurred at the visit.

For your convenience we accept cash, check, Visa, MasterCard and American Express. Please ask our staff about our Auto Pay option.

- **Insured Patients**: Please come to all appointments with the necessary insurance information/card(s) so that we have the information to bill the insurance in a timely and accurate manner. If you do not have your child's insurance card upon check-in and we cannot verify coverage, you will be considered a self-pay patient. As a self- pay patient all labs or imaging will be sent to or done through Legacy. If your insurance requires the lab work to be sent to a different lab or imaging done at a different facility, the cost incurred from these labs or imaging will be billed directly to you by Legacy. If the information is not provided in a timely manner and the clinic is unable to bill for the charges within the time limits set by the insurance companies, the balance will become your responsibility.

- **Newborns**: Please contact your insurance company as soon as possible after the birth of your child. Most health plans allow 30 days to add your newborn otherwise you may have to wait until an open enrollment period to add coverage for your new baby.

- **Self-Pay Patients**: **If you DO NOT have proof of insurance, you will be considered a self-pay patient**. For those who have no insurance, the Oregon Vaccines for Children program will cover the cost of vaccines but not the current administration fee per vaccine.
    - For well visits, all self-pay patients will be required to make a $100 deposit at the time of the visit with any remaining balance being billed to you. If you are unable to make the $100.00 deposit at the time of service we will request that you set up a monthly payment plan with us before your visit.

- **Cancellation Policy:** We ask that you notify us by **8 am** on the day of your scheduled appointment if you are unable to attend. This will allow another patient in need of care to be seen. For appointments that are not kept and not cancelled by 8 am on the day of the scheduled appointment, PANW reserves the right to apply a $25 fee to your account. Patients may be asked to pay an outstanding cancellation fee prior to being seen for their next appointment.

- **Existing patients with delinquent accounts, accounts turned to a collection agency, claimed bankruptcy, or have balances written off to bad debt**: Payment in full required at time of visit less 25% (except on vaccines/supplies) unless your insurance covers 100% of the charges.
- We do offer a 25% discount (except on vaccines/supplies) to all patients who pay in full on the date of their visit. If you would like to take advantage of the 25% discount please let the receptionist know when checking in your child.
- When children are scheduled for **preventative care (**well child visits), it is your responsibility to verify insurance benefits before the appointment. We have staff at each office that can assist you with this. If the insurance does not cover routine services such as vaccinations and well child visits, the balance will be your responsibility. We cannot change billing codes once the insurance has been billed for a service.
    - If your child is sick on the day of the well child appointment, we can either see your child for the sick visit and reschedule the well visit or see the child for both. Insurance may not cover both the well and sick visit on the same day and you may be responsible for any balance.

- **Co-payments**: If your insurance has a co-payment, it is due at the time of your visit. If you fail to make a co-payment on the day of the appointment, a $25.00 billing fee will be added to your account.

- **Non-Sufficient Funds**: When checks are returned to us because of non-sufficient funds a $35.00 charge will be added to your account and you will be asked to pay by cash or credit card for future visits.
- All balances are due within 30 days of the first statement. Please contact our Billing Office at 503-419-4923 if you have any concerns regarding your bill so that we can discuss it with you.
- Delinquent accounts more than 90 days past due, with no payments and/or broken payment arrangements are subject to collection activity. You will be notified in writing and by phone (if possible) prior to any action.

- **Collections**: In the unfortunate event that we need to assign an account to a collection agency we will be adding an additional fee of $150.00 to the delinquent balance on the account. Any discounts will be added back to balance and amount sent to the collection agency will be the full fee. The second time a family is assigned to a collection agency the family will be dismissed from our practice.
- We know circumstances arise preventing you from coming to your appointment. Please call 24 hours in advance to cancel or reschedule appointments. If a family has ongoing missed appointments without contacting the clinic, the family may be dismissed from our practice.

During these challenging financial times, it is our desire to keep your medical expenses at a manageable level. Should you receive a bill from us and find yourself in a financial bind, please call us to discuss setting up a payment plan. If more charges are added to the

balance, new payment arrangements will need to be made. We are happy to help and are here to assist you.

As guarantor of the patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of Pediatric Associates of the Northwest, P.C. I authorize my insurance benefits be paid directly to the provider. I authorize the provider to release any information required for this claim.
I have read and understand this payment policy.

_____ _____
Signature Date

_____ _____
Printed Name Child(ren)

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