Sunshine Pediatrics Financial Policies

In order to ease the transition from the ***practice*** of medicine to the ***business*** of medicine, we have enacted certain policies, which we have outlined below. Many of these policies come from an effort to reduce our costs, and therefore yours. Please call our billing office if you have any questions.

PAYMENT DUE AT THE TIME OF SERVICE

This is just a fancy way of saying that what you owe for your visit will be collected when you are here for that very visit. In certain cases, like to hold an appointment spot, for example, we may ask for payment before the visit. We accept VISA, MasterCard, cash, check or money order.

1. **WHO BRINGS PAYMENT:** Payment is due regardless of who brings the child in for the service. Grandparents, babysitter, aunts, etc., will be expected to bring in payment for your copay, co-insurance or deductible. If you are reachable by phone, we can take your credit card information over the phone and send the receipt home with your child's caregiver. For separated or divorced parents, financial responsibility still belongs to the parent bringing that child in for treatment. We will not bill another parent; it is your responsibility to bring what you will owe when you arrive.
2. **LATE FEE:** There is a $10 late-fee for any expected payments not made at the time of service, unless paid within 24 hours.
3. **FINANCIAL RESPONSIBILITY:** Payment is determined from benefits we receive from your insurance company. Regardless of what is quoted or misquoted by them, you are ultimately responsible for any deductibles, co-insurances, or copays that are not paid by your insurance company. This includes services they do not think are medically necessary, or do not cover, but that our providers deem necessary, appropriate and/or a standard of care for pediatrics.
4. **DEDUCTIBLE RESPONSIBILITY:** Deductible responsibilities are also collected at the time of service. If you cannot pay your entire deductible charge for a sick visit, a $50 deposit will be collected toward the balance. If you request to be billed for deductible balances, payment must be made within 30 days, or the privilege of being billed will be lost, and full payment will be expected at each visit. Deductibles and/or other charges for well visits and/or vaccines are expected up front, and are not balance billed.
5. **PROOF OF INSURANCE:** Proof of insurance must be shown at check-in at every visit. Without proof of insurance, you will be charged for the visit in full. For newborns, proof of *application* will be expected by the 30-day mark for those still not added to the insurance. Most commercial insurance companies allow only 30 days to add your newborn to your plan. Please do so as soon as possible. All newborn bills will be held and sent to the insurance company once it can be verified that the newborn has coverage. By 2-months of age, all babies without proof of insurance will be expected to pay in full for their 2-month well visit and all visits since birth.
6. **WELL AND SICK VISITS AT THE SAME TIME:** Your insurance company may cover well and sick visits differently, and it is very important that you familiarize yourself with the details of your insurance coverage. No one likes being surprised with a bill! While some insurance companies may pay for well visits 100% (where there is no cost to you), sick benefits may include a copay, co-insurance, and/or deductible. If during a well visit your child is sick or has an issue that is not related to the normal growth and development of your child, and he/she needs treatment and/or medical attention for your concerns, *your provider may bill the insurance company for both services*. Regardless of whether there is no charge for the well visit, you will be responsible for any charges passed on to you for the sick visit portion. Conversely, the provider may decide to reschedule the well visit and focus on the issue that is causing the concern. In either case, you will be asked to pay for the sick visit portion of your visit while you are here just like if you had scheduled a sick visit that very day.
7. **SECONDARY INSURANCE.** We do not bill secondary insurances except in cases of disability. In such cases, we will collect the copay, co-insurance or your deductible responsibility for your *secondary* insurance at the time of service. We do not bill tertiary insurances.

INSURANCE

While insurance companies are better about giving us accurate information, the information they neglect to tell us can often times prevent a claim from being paid. Sometimes they are simply waiting for you to call them to give them some information they need. They will deny payment until they hear from you. Some of these "reasons" include that they are (1) waiting on you to contact them because they want to find out if you have another insurance that would be responsible for the charges, instead of them, (2) waiting to hear from you regarding a discrepancy in demographic information, e.g., an incorrect birthday or sex., or (3) waiting on you to name a primary care physician for your child's care. Please be aware, balances not paid by them in 30 days for no fault of ours, will become your responsibility. So please, open your mail and answer their questions....we would greatly appreciate it!

We are in network with most major insurance companies, but if we are not, we can bill as an out-of-network provider if your insurance accepts such claims. Ultimate responsibility in finding out if we are an in-network provider rests with you, however. Plans change annually and so can their networks or our affiliation with certain networks. If we are out-of-network, you will be responsible for any out-of-network charges, which are usually higher than those your insurance company passes on to you for in-network providers. When you purchase a new insurance plan, please call them to make sure we are in-network before you sign on the dotted line.

BALANCES

While no one likes to discuss paying bills, it's a necessary evil we must all face. In order to improve our office efficiency, reduce our overhead expenses, and ensure that we can financially sustain ourselves in order to continue providing our patients the services they are accustomed to, the following are our policies regarding outstanding balances.

All outstanding balances not paid within **90 days** may be turned over to a collections agency, and a discharge notice terminating patient care will be sent to you. All costs incurred in collecting a delinquent account will also be added to your charges. During this 30 day period, discharged patients will need to transfer medical care to another physician's office, however, we will continue to provide medical care to you during this time period. If the balance is not paid within that 30 days, patient care will be officially terminated. Depending on the amount of the balance, payment plans for no more than a 3 to 6 month time frame may be granted on an individual basis. Any payment plan obligations not met, or not attempted to be met, will be immediately turned over to collections and patient care terminated as described above. While we find it unethical to prevent you from obtaining your existing records because of a balance, we do expect that any outstanding balances must be paid in full before receiving a certified copy of the SC Certificate of Immunization, a sports/camp or other physical form, FMLA papers, any letters requested for an outside agency, school, attorney, or anyone else, or any other administrative services, that we usually provide at no charge for our patients.

TRANSFER OF RECORDS AND FEES. We do not charge a fee for faxing records to another office, but there are associated charges when a paper copy is requested. We make every effort to honor any request for personal copies within 10 business days, but no more than 30. Fees include a flat fee for processing, a per page fee, and a flat mailing fee if records are to be mailed. For faster service, all payment for records must be received in advance by cash, credit card or money order. We reserve the right to hold records until a payment by check is cleared and posted. If you are moving, a release of medical records can be signed at our office if you know the new physician's practice information, it can be taken with you to fill out, sign and send to us when you get there, or one can be signed at your new office and faxed to us from there. For any portion of your child's record that needs to faxed to you, to a school, to a non-medical office, or elsewhere, we will require a signed release from a parent or legal guardian before doing so. There is no charge for this service. This release also serves as a written disclosure of your child's medical record that we are legally required to maintain. Please also read our Notice of Privacy Practices regarding our policy for providing records.

RETURNED CHECKS: All returned checks will be turned over to the York County Solicitor's Worthless Check Unit, unless payment of the face value of the check, including a $30 charge, is not paid within 3 days of being notified. Once turned over to the Solicitor's Worthless Check Unit, you will be charged our $30 fee in addition to the face value of the check, another fee from them, and possibly face arrest and criminal prosecution. Any family that has a 2nd check returned for insufficient funds will be turned over to the Solicitor's Worthless Check Unit, immediately, and will not be allowed to present checks as a valid form of payment. Only credit card, cash, and/or money order will be accepted.

VACCINES AND THE UNINSURED

If your child does not have insurance, the cost of your vaccines will be picked up by the federal government, under the Vaccines For Children (VFC) program. There will be a $13 administrative fee for each vaccine, up to a maximum of 3 vaccines per visit – even if you are given more than 3 vaccines at that visit. This charge is in addition to any charges for the well visit that the provider does. You may also go to the York County Health Department for vaccines. Please call our billing department for more information.

HOW DO YOU KNOW WHAT IS COVERED?

When you have a new plan, it is important to discover what your per visit responsibilities could be. Knowing the financial lingo involved is sometimes half the battle. Here is a short glossary of terms that you should be familiar with, and questions you can ask your insurance company to make sure you know what you will be expected to pay when you come for your visits. Keep in mind that you could call your insurance three times and get three different answers to the type of coverage you have. We run into the same problem if we call, so it is very important to read the handbook that is given to you when you get your insurance plan. That is your written contract with them. Don't forget to read the fine print!

GLOSSARY OF TERMS:

TYPES OF VISITS

1. **CHECK-UP** - This is old term used to describe any type of doctor visit. Most people still use this term to indicate a well-visit, but some use it for both well and sick visits. For that reason, we avoid using this term as much as possible. Consider using sick or well visit to be more specific.
1. **IMMUNIZATIONS/VACCINES -** The terms "vaccines" and "immunizations" can be used interchangeably. These are life-saving injections that help your child's immune system fight a particular disease, like pertussis (whooping cough), polio, or meningitis. Many vaccines require boosters, which are additional doses given to continue revving up your child's immune system so that it doesn't forget how to fight that deadly disease.
2. **SICK VISIT -** Any visit that is focused on a specific concern or problem. The child doesn't necessarily have to be "sick" to fall under this category. A rash, twisted ankle, or behavioral concerns would fall under the sick visit category because it focuses on a specific concern.
3. **WELL VISIT -** Any visit that is routine in nature (e.g. regularly scheduled) that concerns the growth and development of your child at various stages of his/her childhood. This usually refers to the part of the visit that the doctor or nurse practitioner does.

INSURANCE TERMS THAT MEAN YOU HAVE FINANCIAL RESPONSIBILITIES

1. **CO-INSURANCE** - This is a fee you pay based on a percentage of the reimbursement the office will receive for providing your services. If for example, the insurance pays $100, and you have a 30% co-insurance, you will be required to pay $30 at the time of service.
2. **CO-PAY** - A flat fee you have to pay at *every* visit. This is a fee that your insurance company requires you to pay. Contracts between insurance companies and medical offices often stipulate that a patient must pay their copay in order to be seen. This implies you can be turned away if you do not have copay. For ethical reasons we do not do this, but we do charge a late-fee if you cannot pay your copay within 24 hours.
3. **DEDUCTIBLE** - The amount you have to pay *before* the insurance will pay for anything. A deductible can be $500 or $5000. It is very important to know how much your deductible is and if it has been met. The insurance company allows a certain charge for each service we provide. That charge is called the allowable. You will be required to pay the allowable amount for the services you received at the time of your visit. We will still send a claim to your insurance company so that they know to apply your charges toward your deductible. For more information on our policies regarding deductibles, please read "Deductible Responsibility" under the section called Payment Due at the Time of Service.
4. **MAXIMUM BENEFIT OR CAP** - This is a dollar limit on how much your insurance company will pay for a particular type of service. They may only pay, for example, a maximum of $500 for a well visit and immunizations. After this $500 has been reached, you would be paying for the service in full, as if you had no insurance. Some insurance companies limit the number of visits, instead of putting a dollar limit on a service. For example, there are typically 6 well visits scheduled before a newborn turns 12 months old. An insurance company may limit it to 5 out of 6 visits.

QUESTIONS TO ASK YOUR INSURANCE

1. What are my vaccine benefits? Does a deductible apply? How much? Do I have a co-insurance? How much? Will a copay apply if I only need to get vaccines and do not see my doctor? Is there a maximum benefit or cap on my vaccine benefits? What is that limit?
2. What are my sick benefits? Is there a deductible? Co-insurance? Copay? How much in each case?
3. What are my child's well benefits? Does a deductible, co-insurance or copay apply? How much? Is there a maximum benefit or cap on these services? What is the limit? Is there a limit on the number of well visits I can have in a year? If so, what? Do well benefits end at a certain age?
4. What is my benefit year? Does it start over on Jan. 1st? Can my (older) child get one well visit per calendar year or benefit year?
5. For any of these services, do I have a copay *and* co-insurance? To which services does this apply?
6. Is this information all spelled out clearly in my benefit handbook? If not, can I get this in writing? Is this information available online to me?

For questions on any of our financial policies, please call our billing department at 803-980-7337, option 4.