2244 Henderson Mill Road, Suite 108 | Atlanta, GA 30345 | 770.239.2500
www.briarvistapediatrics.com

Financial Policy

Insurance:
As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you read your insurance policy to be fully aware of any limitations of the benefits provided. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you.

Copayments and Deductibles:
Depending on your insurance policy, a copayment and/or deductible or coinsurance may be required at the time of service. Payment may be made in cash, by check or by credit card. We also accept Health Savings Account (HSA) cards for payment.

Please note that the copayment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. Coinsurance may apply even after meeting your deductible. Please see our "Insurance 101" document on our website for a better explanation of these terms.

Patients Without Insurance Coverage/Non-covered expenses:
We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit. The same discount will be applied to any non-covered charges for patients with insurance, if paid at the time of service. This discount can not be applied toward the "patient responsibility" portion of covered charges, as those charges are already discounted through the contract we maintain with your insurer.

Financial Arrangements:
Because we realize that every person's financial situation is different, we provide a variety of payment options. For your convenience, we accept all major credit cards and checks. (Returned checks will be subject to a $35 returned check fee). If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Briarvista Pediatrics complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Briarvista Pediatrics cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-408-2431. TTY: 711.

Appointments/Cancellations:
We gladly reserve appointment times for you and appreciate that you have chosen Briarvista Pediatrics for your care. As a courtesy, we will remind you of your appointment by calling and/or sending a text or email to remind you of your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment.

We reserve the right to charge $25 for regular appointments cancelled without advance notice of at least 1 business day. Appointments that are scheduled for the same day and then cancelled, as well as no-shows for an appointment, may be assessed a $50 charge. After three no-shows or same-day cancellations, your family may be dismissed from the practice.

Patient/Parent/Guardian Responsibility:
- I understand that whomever accompanies my child to their appointment has authorization to consent to medical care as needed, *and is responsible for payment of medical services.*
- I acknowledge my responsibility for payment of all services provided by Briarvista Pediatrics in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Late Fees:
I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:
I authorize payment to be made directly to Briarvista Pediatrics by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

Credit Card on File Policy:
Briarvista Pediatrics is committed to making our billing process as simple and easy as possible. We require that all patients provide a credit card on file with our office. We will scan your card with a card reader. It will store your card number is a secure, compliant location in your electronic medical record. For security reasons only the last four digits will be visible to our staff. Credit cards on file can be used to pay copays and other charges (such as toward the deductible or for non-covered services) at the time of the visit.

Once processing the visit with your insurance, you may owe part of the patient responsibility fee. If we do not receive payment for the amount listed on your statement within 13 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed. Your account becomes delinquent if not paid within 30 days after the date of the original statement. The unpaid balance will be subject to a finance charge of 1.5% (18% APR) or $35, whichever is greater. Further delinquency will be subject to collections with additional finance fees.

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For families who do not wish to leave a credit card on file, you will be obligated to maintain a $50 balance, per child, with the practice. That balance will be used for any unpaid patient responsibility, as outlined above, and will need to be replenished before a member of the family can be seen in the practice again.

By signing below, I give Briarvista Pediatrics permission to charge my credit card for any patient balance due on my account. If I have insurance coverage, my card will be charged AFTER my insurance has paid their portion.

Name (please print): _______________________________________ Date: ______________________

Patient's Name and Birth Date:

____

Signature of Responsible Party (Guarantor):

____

Relationship to Patient(s) (please check): ___ Parent ____ Self _____ Other: _________________

Witness Signature:

____

Note: *The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.*

Notice of Privacy Practices Written Agreement:

I also acknowledge that I have read a copy of Briarvista Pediatrics' Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand Briarvista Pediatrics has a link to the Notice of Privacy Practices on the practice website (www.briarvistapediatrics.com).

Name (please print): _______________________________________ Date: ______________________

Signature of Parent / Guardian / Patient:

____

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