Pediatric Neurology of Lehigh Valley
Boosara Ratanawongsa, M.D
961 Marcon Blvd. Suite #452
Allentown, PA 18109
(P) 610.398.9898
(F) 610.398.9899

FINANCIAL POLICY

Thank you for choosing Pediatric Neurology of Lehigh Valley to care for your child's neurological health care needs. If you may have any further questions or concerns after reviewing this form, please do not hesitate to ask any one of our staff members for assistance. We look forward to the opportunity to provide you, your family, and your child with compassion and exceptional care. The following is a statement of our Financial Policy. Please read prior to your appointment.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

All co-payments, co-insurance, and deductibles are due at the time of service, prior to seeing the provider. We accept cash, checks, Visa, Mastercard, Amex and Discover. Additionally, you will be asked for a credit card at the time you check-in. We will scan the card in our system, and the information will be held securely until your insurance has paid their portion and notified us any additional amount owed by you. At that time, you will receive a notification that the remaining balance owed will be charged to your credit card. Please note that there is a $35.00 fee for returned checks.

INFORMATION REGARDING INSURANCE

Contracted Insurance Plans: Although we have contracted with your insurance company to provide care to their clients, your insurance policy is a contract between you and your insurance company. All co-pays, deductibles and co-insurance percentages are due prior to treatment. Payment for the visit is your responsibility. It is also your responsibility to ensure that you obtain an insurance referral from your primary care physician if one is required. If you are treated without a referral, you will be responsible for the charges incurred. If we do not have the updated insurance information at the time of the appointment you will be responsible for the entire visit, and you must submit to your insurance company for reimbursement.

Non-Contracted Insurance Plans: We are not contracted with Medicare or any form of (MA) medical assistance and will not bill MA or Medicare. You are responsible for payment of all services rendered whether covered by insurance or not. For non-contracted commercial insurance plans, to assist you, we will bill your commercial insurance company. If we don't have your updated insurance information on file at the time of your visit, you will be responsible to pay all costs and you must submit to your insurance company for reimbursement. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Non-covered services: Please be aware that some – perhaps all – of the services or diagnoses you receive may be non-covered or not considered reasonable or necessary by your insurance company. This includes, in accordance with AMA CPT guidelines, we reserve the right to charge for telephone/video calls, after business hours/weekend appointments with Dr. Boo that include evaluation and management of your medical condition. We will bill your insurance for such charges, but if it is not covered by your plan, you will be responsible for the charges. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

OTHER FEES

Missed Appointments: We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24 hours/1 full business day prior to canceling your appointment. Unless canceled at least 24 hours/ 1 full business day) in advance—i.e., by Friday morning for a Monday morning appointment, our policy is to charge for missed appointments at the rate of $125.00. This is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

Collections: You will be dismissed from the practice if you fail to meet your financial responsibilities within 60 days and/or we must use a collection agency to bring your account up to date.

Minor Patients: Please note that the adult accompanying the minor child to the appointment and the parents (or guardians of the minor) are responsible for full payment at the time of the visit.

Forms: There may be a minimal charge of $10.00 and up to a maximum of $50.00 for completion of any forms not completed during a scheduled office visit.

Right to Amend: You understand and agree that PNLV may amend the terms of this Financial Policy at any time without prior notification to the patient.
Please keep this policy for your records. Sign the following acknowledgment and return to the staff of PNLV to keep on file.

Assignment of Benefits: I hereby assign, transfer, and set over directly to Pediatric Neurology of Lehigh Valley (PNLV) sufficient monies and/or benefits for basic and major medical to which I may be entitled for professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in said practice. I authorize PNLV to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to PNLV, I authorize PNLV to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, other physicians or providers, and any other third-party payers.

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FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

By signing below, you are acknowledging that you have read, reviewed carefully, and fully understand our Financial Policy and accept your financial responsibility to Pediatric Neurology of Lehigh Valley. Furthermore, you understand it is your responsibility to stay compliant with our financial practices. You understand that you are obligated to ensure payment of the fees stated in our Financial Policy, in full and in a timely manner.

Patient Name:________________________________ DOB:________________________________

Guarantor Name:______________________________ DOB:________________________________

Parent/Guarantor Signature:______________________ DATE:________________________________