Dr. ASEEMA RAOSHAN, M.D

11914 ASTORIA BLVD # 450, HOUSTON, TX, 77089.
1111 Highway 6S, Suite 120, Sugar Land, TX 77478.

*OFFICE FINANCIAL POLICY, *POLICY FOR APPOINTMENTS, *AFTERCARE, *TEST RESULTS, *MEDICATION

Thank you for choosing us as your healthcare provider. We are committed to providing you with best possible medical care at the lowest possible cost. In order to keep our fees to minimum we require that you pay at the time of service so, that we do not have to send bills. **We may order laboratory test, perform office procedures or diagnostic test as part of our comprehensive evaluation. Payment for these services are due and payable at the time of service.** In order to achieve the clinic goals of providing the finest medical care at the lowest cost, we need your assistance and understanding of our payment policy.

Insurance:

PAYMENT OF CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. Service may be **denied if payment is not made at check- in time.** Our office will file an insurance claim for services rendered, but ultimately you (PARENT) are responsible for the bill. By law your insurance company must remit payment or deny your insurance claim within 30 days of initial notice. If you're insurance has not paid your account in full within 45 days we may ask for your assistance getting your insurance company to pay the balance OR the balance may be billed to you. We will file claims to your insurance **but your insurance policy is a contract between you and your insurance company.**
All balance will be due immediately.

1. **Co-payments and deductibles**: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
2. **Non-covered services**: Please be aware that some – and perhaps all of the services you receive may be non-covered or not considered reasonable and necessary by Medicaid or other insurers. You must pay for these services in full at the time of visit.
3. **Proof of insurance**: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance to provide proof of insurance at each visit. Often this verification requires us to share the reason for your visit with your managed care plan.

4. **Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.

Self- Pay

FULL PAYMENT FOR PROFESSIONAL SERVICE DUE AT TIME OF SERVICE.
Methods of payment include cash, checks, debit/ ATM cards, visa, MasterCard, Discover.

Refunds

We will **refund you within 30 days after the date that we determine an overpayment** has been made OR the balance stays on your account and/OR can be used for future visits copays/deductibles. Please notify our billing office if you are aware of any overpayments.

Insurance Coverage Changes

Please understand that it is **your responsibility to provide us with any new, updated or additional medical insurance and changes if any.** In the event, that your insurance coverage changes to a plan in which we are non- participating providers, then, we are unable to verify benefits, and you will be responsible for payment of all fees at the time service is rendered. We will file insurance claims immediately for all services, if requested, and reimbursement from the insurance carrier should be made directly to you. We can provide you with necessary documents for reimbursement. Again, if payments received by the office, a check will be issued to you within 30 days for reimbursement. We ask that you participate in any disputes with your insurance carrier regarding your policy guidelines, coverage and insurance payments.

1. **Coverage changes:** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.
2. **Indemnity/Fee for Service**: We require full payment at the time of service. We will supply you with a copy of your itemized statement so that you can file for reimbursement from your insurance company. Should your insurance company require a more detailed description of services, please have them request it in writing. Insurance is a contract between you and your company. We are not a party to your contract. We will not become involved in disputes between you and your insurance. You are responsible for timely payment of your account.
3. **CONTRACTED MANAGED CARE PLANS (HMO, PPO, POS, EPO)**

Each time you make an appointment with us, it is your responsibility to make sure the patient is currently under contract with your managed care plan.

4. **Verification of your coverage and benefits may be required.** Often this verification requires us to share the reason for your visit with your managed care plan.

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Financial Responsibility for Minors:

Unless prior arrangements have been made, **charges for minor child** seen in the office will be the **responsibility of the adult/parent accompanying the minor child**.

UNACCOMPANIED MINORS: Minor must have an authorization for medical treatment signed by his/her parent/guardian and is responsible for providing current insurance information for self. Please note that co-payments and/or deductibles are expected at the time of service.

REGARDING DIVORCE:

We do not get involved in disputes between divorced parents regarding financial responsibility for their child's medical expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on your former spouse.

Medical Records Request

There will be a **$25 fee or more based on number of pages requested** (Texas medical Board rule 165.2[tmb.state.tx.us]) for every medical records request. Please **allow 7-10 business days** to process medical records request.

Child Disability form and/or Family Medical Leave Act (FMLA) Forms

There will be **a $10.00 or more (fee based on how extensive paper work is)** for completion of all Disability and/or FMLA form. These forms require physician review so please **allow 7-10 Business days** for completion.

No Show Policy

AR TEXAS PEDIATRICS, PLLC's appointment reminder service calls or texts patients at least 24 to 48 hours prior to their scheduled appointment to confirm the appointment. Since, our office appointments are usually filled up to 6 weeks in advance, we require at least 1 business day notice for cancellations, so that we will have the opportunity to offer the time to other children/patients. AR TEXAS PEDIATRICS, PLLC reserves the **right to charge $25.00 fee for NO SHOW appointments.** To avoid this fee, Please, call our office to reschedule or cancel your appointment at least 24 hours before your scheduled appointment. This **fee is NOT billable to your insurance company and will be your responsibility.**

After hours Calls

Your physicians is on call after- hours and on weekends for serious/urgent medical problems or for medical emergencies. For routine medical questions or minor problems, please call during regular business hours. A **charge of $20 will be added to your account for any non- emergency calls.** This **fee is NOT billable to your insurance company and will be your responsibility.**

Daycare, School or afterschool programs forms

There will be **a $10.00 or more (fee based on how extensive paper work is)** for completion of documents form. These forms require physician review so please **allow 7-10 Business days** for completion.

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Letter request form

There will be **a $10.00 or more (fee based on how extensive paper work is)** for completion of documents form. These forms require physician review so please **allow 7-10 Business days** for completion.

Immunization records

There will be a **$5.00 fee for a copy of shot record**. This is administrative fee for printing, emailing or faxing.

Follow up visit

Following your visit with the doctor when labs, or radiology and special tests are ordered as part of new patient work up or as a part of a patients continued ongoing care process, you will be asked to schedule a follow up appointment to review these results. Some normal and benign labs are reported by staff after review by Dr. Raoshan. The recommendations come from Dr. Raoshan. A scheduled follow up visit with the physician is preferable so that all questions can be answered fully. We will try to facilitate your needs as best we can. You can be assured that you will be contacted by the office staff should any test results require action prior to your scheduled follow-up appointment.

Medication

To obtain refills for medications prescribed through this office you are required to come for continued ongoing care at least once a year, and possibly more frequently depending on the condition ADHD, Asthma and Allergy follow up are every 3 months. Medication refills will not be approved after office hours or on weekends. If you have not been seen in the past 3 months medication refill will not be approved.

Late fee schedule

Payments are due at the time you receive patient statements. If the payments are not received with first notice a late fee applies. If patient balances are due over 30 days a late fee will apply. See late payment fee schedule.

- $25 if balance is less than $100.00 up to
- $37.00 if balance is between $100.00- $250.00
- $47.00 if balance is greater than $250.00.

If NOT paid after 3 reminders, the account will be sent to collections, and it will be your responsibility to work with the collections. This amount must be cleared before the child or sibling must be seen. Billing office reserves the right to deny service if this balance is not cleared.

As we stated above, the primary goal of our practice is to provide the finest medical care and service to the people in our community. Since our practice also has financial obligations which must be met we ask that all patients pay for their examination and treatment in full on the day of each visit to our office. Regarding **insurance plans where we are a participating provider, all copays and deductibles are due prior to treatment.**

For All Visits : Please do not forget to

1) Bring a current immunization record and all relevant medical information.

2) Bring a copy of your current valid insurance card.
3) Ensure the doctor listed as your PCP (for HMO, CHIPS or Medicaid) is Dr. Aseema Raoshan, MD.
4) Arrive 15 minutes prior to your appointment and come 20 minutes prior to your appointment if your insurance or demographic information has changed.

Initial Visits : In order to save you time during your initial visit, please complete our patient forms on our website**,** **www.artxpeds.com.** You can print and return the copy via email- info@artxpeds.com, fax (281) 484-7632. You may also make an account on the Patient Portal link and input all your information directly onto our electronic medical records. Additionally, you may request these forms to be emailed to you. If you are unable to fill out the forms before you arrive at our office, please come thirty minutes prior to your appointment so that you will have ample time to complete these forms.

Sick Visits: Please contact our office as soon as you feel your child needs to be evaluated. Please call early in the day so that we can give you the appropriate advice. We can see sick patients on the same day the appointment is made. **No Shows and Tardiness:** We strive to offer excellent service to our patients in a timely manner. It is unfair to others if you do not show up for your appointment, come late or walk in without calling first. If you have an appointment and cannot make it, please contact us to either cancel or re-schedule your appointment 24 hours in advance. If you know you will be at least 15 minutes late for your scheduled appointment, please call us as soon as possible, so we may adjust our schedules appropriately.

Assignment: I hereby authorize payment directly to AR Texas Pediatrics, PLLC. Any changes in this authorization must be received in writing within 30 days of the effective date. In the event my insurance company deems a service to be “non-covered” I understand that I am personally responsible for payment.

I agree, to the release of all medical information, including HIV test results, other confidential labs and financial information necessary to process this and any future claims to my insurer or payer of health benefits, as I may designate that person or entity from time to time, for an indefinite period or until I submit a written revocation of this release. Any changes to this authorization must be received in writing within thirty days of effective date.

Parents are giving AR TEXAS PEDIATRICS, PLLC permission to contact them via mail, e-mail, phone call, voice mail, Fax and/or text message.

Guarantor Signature: _____ **Date:** ____/____/_____

Print Name: _____**Guarantor Date of Birth:** ____/____/_____

Relationship to Patient: _____

PATIENT(S) NAME: _____ **Date of Birth:** ____/_____/_____