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

Payment is due at the time of service or your child may not be seen by the physician. We accept Cash, Check, Discover, Visa and MasterCard as forms of payment. There will be a service charge of $25 for returned checks. _____(initial)

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, along with a valid referral from your primary care provider, if your insurance plan requires it. As a courtesy, we may verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of all services. A list of visit charges for office visits are available at your request. _____(initial)

Non-Contracted Insurance Plans: We are **not** contracted with Medicare or any form of (MA) medical assistance and cannot bill MA or Medicare. You are responsible for payment of all services rendered. For non-contracted commercial insurance plans, to assist you, we will bill your commercial insurance company. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. _____(initial)

Self Pay: If your child does not have health insurance, you will be responsible for services rendered here at Pediatric Neurology of Lehigh Valley. You are responsible for prompt payment to Pediatric Neurology of Lehigh Valley of the full and entire amount of treatment provided to you or your child, at each visit. _____(initial)

Usual and Customary Charges: Pediatric Neurology of Lehigh Valley is committed to providing the best treatment for our patients. We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. You will be responsible for payment in a timely manner if your insurance carrier authorizes and certifies care but fails to pay as agreed upon. _____(iniitial)

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. We ask that minors be accompanied by a parent or guardian to each appointment, and that if the person accompanying the child is not the guarantor, payment arrangements must be made in advance, prior to our provider seeing the patient. _____(initial)

OTHER FEES

Missed Appointments: Children who are not present for their appointment will be charged a missed appointment fee and scheduled for another day. We require 24 hours notice/1 full business day for cancellations. Example: 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. _____(initial)

Collections: You may be dismissed from the practice if you fail to meet your financial responsibilities within 4 months (120 days) and/or we must use a collection agency to bring your account up-to-date. If it is necessary to turn the account over to collections and you wish to return to the practice, you will be responsible for all charges, including those incurred to collect the amount owed, i.e. collections agent's fees. _____(initial)

Returned check fee: There will be a service charge of $25 for returned checks. _____(initial)

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. _____(initial)

Medical Records: There may be a charge for copying medical records. Price depending on number of pages needed to be printed. _____(initial)

Please keep this policy for your records. Sign the following acknowledgment on the next page and return to the staff of PNLV to keep on file.

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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 all of 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:_____