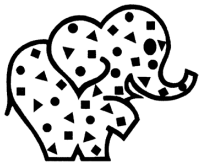

Foster City Pediatric Medical Group, Inc.
Financial Policy

Financial Policy: A solid foundation for patient responsibility & payment

Thank you for choosing Foster City Pediatric Medical Group, Inc. as your healthcare provider. We are committed to your treatment being a successful experience. Our Medical and Business Office staff members will work very hard to make sure your paperwork is filed accurately and promptly.

WE ACCEPT MASTERCARD, VISA, DISCOVER, DEBIT CARDS, CHECKS AND CASH.

Assignment of Benefits:
Payment is due and payable at the time of service unless arrangements have been made in advance with our office prior to our providing services to you.

Foster City Pediatric Medical Group will bill all primary and secondary insurances, but I am ultimately responsible for the payment for the services and equipment I receive.

I hereby assign to Foster City Pediatric Medical Group any insurance or other third-party benefits available for health care services provided to me. I understand that Foster City Pediatric Medical Group has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Foster City Pediatric Medical Group, I agree to forward to Foster City Pediatric Medical Group all health insurance and other third-party payments that I receive for services rendered to me immediately upon receipt.

I understand that my signature requests that payment be made directly to Foster City Pediatric Medical Group, Inc. I authorize release of medical information necessary to pay the claim.

A photocopy of this assignment is to be considered as the original.

Patient's Name: _____
Signature of Patient/Legal Guardian: _____
Date: _____

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Insurance & Insurance Collection:

We will attempt to bill your insurance company as a courtesy. Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. Our billing staff has undergone extensive training to maximize your insurance reimbursement while reducing the time by which they pay.

- **Non-Contracted / Indemnity Insurance Plans/No Insurance Card:**

If you are unable to present an insurance card at the time of service or if you are covered by an insurance company with which we're not contracted, we require that you pay for services in advance. If we are able to collect from your insurance company, we will issue a refund to you.

We will attempt to bill your insurance company as a courtesy. Our office, as a convenience and a service to you, will absorb all costs incurred for billing. Please note that not all insurers will agree to contract with

us. **In the event that your insurance does not reimburse us within 90 days, we will transfer the balance of your account to your responsibility and send you a statement.**

Regarding Insurance Plans in which Foster City Pediatric Medical Group is a participating provider:

- **KNOW YOUR PLAN BENEFITS; NON-COVERED SERVICES ARE YOUR RESPONSIBILITY.**

Each and every insurance company and plan, including Medicare, has different plans, each with different benefits. Your Foster City Pediatric Medical Group Physician may provide services that are not covered as a benefit of your plan. Patients or Guarantors are financially responsible for any and all services provided that are not covered by your insurance plan. **It is your responsibility to know your insurance plan and the benefits provided.**

- **HMO PLANS.**

All co-pays must be satisfied each and every visit. This is a requirement of your insurer; there can be no exceptions.

- **PPO PLANS.**

We have agreed to accept the discounted rate from your plan, however all co-payments, co-insurance and/or deductibles are your responsibility.

- **Self-Insured/Union Plans:**

Your employer may be self-insured, using an insurance company for administrative and claims processing services. This office has been thoroughly trained on how to get reimbursed by your employer; however, in the event there is a problem, you must provide us with the name of your human resources director and/or benefits manager. We may also require your authorization to file complaint letters to the Department of Labor and your administrator if necessary.

- **Secondary Insurers:**

Having more than one insurer DOES NOT necessarily mean that your services are covered 100%. Secondary insurers will pay as a function of what your primary carrier pays. We may bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance(s) has cleared.

- **Divorce Decrees:**

This office is NOT a party to your divorce decree. Adult patients are responsible for their bill at the time of services. The responsibility for minors rests with the accompanying adult.

- **Co-payments:**

All co-payments are due at the time of service. If we request a copay at the time of service, and it is not paid at the time of service, a billing fee of $35 will be added to your balance.

- **Minor Patients:**

The adult accompanying a minor and the parents (or guardians) of the minor are responsible for full payment. For unaccompanied minors, non-emergency, or treatments that are not related to an ongoing care plan, will be denied unless charges have been pre-authorized to an approved credit plan, Mastercard, Visa, Discover, American Express, Debit Cards, or payment by cash or check at the time of service has been verified.

- **About your information:**

Foster City Pediatric Medical Group asks that you bring your insurance card with you to every office visit. It is your responsibility to keep us informed of any changes in your insurance coverage. We require that you update your address, telephone and employer information with us whenever there is a change. We are not responsible for delinquent accounts due to lack of receipt of statements or other correspondence. Notices are assumed to be acceptable if they are returned to us as unclaimed, forwarding order expired, or otherwise undeliverable.

Our goal at Foster City Pediatric Medical Group is to serve your medical needs as well as we possibly can; and we want to make the billing a non-issue right from the start.

- **Forms:**

There will be a $5.00 charge for filling out forms including school forms, child care forms, immunization cards, disability forms, sports forms, etc.

- **Records and Copying:**

There will be a $30 minimum charge for copying materials from your chart when done other than at the time of a visit. This includes copying records to send to another physician or medical facility.

- **Returned Check and Denied Credit Card Fee:**

There is a $25 banking fee for all returned checks. If your check is returned from the bank, we will not accept a check as payment on your account. Future payments must be made with cash, money order or credit card.

There is a $25 fee whenever credit card information is provided and later denied due to insufficient credit (balance) on card information submitted on statements or over the phone.

- **Missed Appointments:**

There is a $25 missed appointment fee if you cancel or reschedule an appointment with less than 24 hours advance notice or if you fail to arrive for your appointment, for well child check ups.

- **Collections/Pre-Collections:**

Foster City Pediatric Medical Group will send you a statement after we have completed our efforts to bill your insurer. If we do not receive payment after 60 days, your account may be turned over to a collections service and a $25 late payment/pre-collection fee will be added to your account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

All patients information is confidential and subject to state laws including Confidentiality of Medical Insurance Act: Section 56 of the California Civil Code.

I have read the Financial Policy. I understand and agree with this Financial Policy.

_____ Date: _____
Signature of Patient or Responsible Party

_____ Date: _____
Signature of Patient or Responsible Party

_____ Date: _____
Signature of Patient or Responsible Party

_____ Date: _____
Signature of Patient or Responsible Party