Financial Policy

Thank you for choosing Atlanta Pediatric Partners (APP) for your child's healthcare. APP is committed to keeping your insurance and other financial arrangement made with us as simple as possible. To assist in meeting this goal, please read and follow the guidelines below.

For Patient with Insurance: APP is a provider of medical services. We are not a party to the contract made between you and your employer and/or your insurance company. Therefore, we encourage you to contact your insurance carrier personally, in order to remain informed of your benefits. Please bring your insurance card to each visit.

If APP is not a participating provider listed on your insurance plan, then payment in full is due today. (See APP's Self –Pay Discount Policy). Since insurance plans cannot guarantee all eligibility or benefits, APP does not guarantee eligibility benefits. In those situations, where the services APP provides are not covered by your insurance carrier, you will be responsible for any and all services over and above your insurance limits, as well as all noncovered medical services.

Co-payments or co-insurances: specified by your insurance carrier is expected at the time of services are rendered. Past due balances must be cleared prior to being seen by the physician. Cash, Checks, money orders, credit/debit cards are all acceptable forms of payment. Instamed is a secure and convenient option for patients to manage their healthcare payments.

The responsible party, the individuals named on the permission form (whether single, divorced or legally separated, friend or relative) accompanying the child at the time of his/her medical visit is the person responsible for making the co-payment and payment of past due balances, regardless of who provides the insurance coverage.

Bills and bill related correspondence are sent to the responsible party named on the insurance card. Please notify APP's billing office at (404) 699-1339, in advance, if someone other than this person should receive copies of bills/correspondences. APP will process and file your insurance claims for medical services performed at our clinic at no cost to you. Any outstanding claims not paid by your insurance company within 60 days of billing will be due by the patient's responsible party.

For Patient without Insurance: Any balance over 90 days old is considered delinquent and will be turned over to an outside collection agency. In the event your account is turned over to collection, you will be billed and are responsible for paying the balance, plus a $30 service charge. Once an account has been turned over to collection, your account must be paid in full before any future services are rendered.

Returned checks are subject to a handling fee of $30.00.

If you have any questions about APP's Financial Policy, please discuss with our business office, (404) 699-1339. Thank you. I have read, understand and agree to my financial responsibilities under this policy.

Parent/Guardian/Responsible Party: _____

Date: _____

I hereby authorize you to use or disclose the specific information described below, only for the purpose and parties also described below

Person or entity requesting the information and authorized to make the requested use or disclosure: **Atlanta Pediatric Partners, P.C. 4579 S. Cobb Dr SE, Suite 300, Smyrna GA 30080**

Continuation of Medical Care

This authorization shall remain in effect from the date signed below and for up to 90 days thereafter. I understand that (Please initial each line):

- ☐ I may inspect or copy the protected health information to be used or disclosed
- ☐ I may revoke this authorization in writing by contacting your office at the address above, attention Privacy Officer
- ☐ Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by HIPAA
- ☐ I may refuse to sign this authorization and that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for the research-related treatment)
- ☐ If this line is checked, I understand that you will receive compensation from a third party for the use or disclosure of my information.

Patient name: _____ Date of birth: _____

Signature: _____

Relationship to patient: _____

Date: _____