Huntsville Pediatric & Adult Medicine
ASSOCIATES

Acknowledgement of Financial Policy

I understand and agree to the following:

- Huntsville Pediatric and Adult Medicine Associates (HPAM) will copy my insurance card and driver's license. I understand it is my responsibility to notify HPAM in the event of insurance coverage change.
- HPAM will obtain demographic information including mailing address, contact phone numbers, and email address. In addition, I understand HPAM may use and disclose demographic and medical information in order to provide a written, telephone, text message, or email reminder of an upcoming appointment. I further understand it is my responsibility to notify HPAM if any demographic information changes.
- HPAM does not accept Worker's Compensation. Patients must contact their HR Department for a provider.
- Payment for co-payments, deductibles, and percentages not covered by insurance are due from me at the time services are rendered. In addition, I understand the amount collected is only an estimate and the amount due may increase due to accounting error, insurance company payments and/or correspondence and additional services provided during and/or after visits including additional lab.
- If I do not have insurance coverage I will be responsible for services rendered at the time of service and any additional services provided after my visit including additional lab services.
- If I am a Medicare recipient, I understand I will be responsible for annual deductibles, 20% co-insurance, non-covered services, and any charges Medicare states I am responsible for.
- A $30.00 service charge will be applied to all returned checks.
- A $25.00 fee will be charged for missed appointments and appointments cancelled less than 4 business hours prior to my appointment time.
- I will receive a separate statement from the Radiologist that interprets all x-rays done at HPAM.
- That a fee is charged for copies of medical records and is due prior to the release of records.
- It is my responsibility to provide all of my insurance card(s) at each visit.
- HPAM may file my health insurance as a courtesy. However, if the insurance company does not make payment to HPAM, it is my responsibility to:
    - 1) contact HPAM to make sure the correct insurance was filed; and
    - 2) contact my health insurance company for reasons for non-payment or underpayment.

  If I do not resolve payment in a timely manner, within 90 days, I will be responsible for the full balance.
- Most health insurance companies have a filing deadline of 90 days. This means HPAM may not be able to file claims after 90 days after the date of service.
- If I do not resolve financial matters within 90 days, HPAM will start collections process that may include discharge from the clinic.
- It is my responsibility to know if my health insurance is in-network with HPAM providers. If it turns out my insurance is out-of-network, then I will be responsible for any outstanding balance.
- Minors must have authorization for medical treatment signed by their parent/legal guardian and are responsible for providing current insurance information for self. Co-payments/deductibles are due at time of service.
- HPAM does not get involved in disputes between divorced parents regarding financial responsibility for the child's medical expenses. By signing as Responsible Party below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangements places that obligation on a different party.

For Insurance Billing:

I hereby authorize Huntsville Pediatric and Adult Medicine Associates (HPAM) to furnish my insurance company with all the information which the insurance company may request concerning me and/or my present illness or injury. I hereby assign to Huntsville Pediatric and Adult Medicine Associates all money to which I am entitled for medical expenses related to the service reported. I understand I am financially responsible to Huntsville Pediatric and Adult Medicine Associates for charges not covered by this assignment.

_____ _____

Patient Name Patient Date of Birth

_____ _____ _____

Responsible Party (Printed Name) Responsible Party (Signature) Date