The Center for Advanced Pediatrics (TCFAP)
FINANCIAL POLICY

TCFAP believes providing and maintaining a positive and communicative physician-patient relationship with our families is important. We want to make sure you understand all TCFAP financial policies relating to your responsibility as well as the responsibility of your insurance company. Please read this carefully. We will be happy to provide further clarification if needed. After your review, please see second page to sign the Financial Policy, Credit Card on File Policy, Annual Administrative Fee and Permission to Treat. If you have any questions, please do not hesitate to ask a member of our billing staff.

Billing/Payment Policy

We participate in many insurance plans including Husky. Insurance plans are complex and differ even within the same insurance company. It is your responsibility to fully understand your plan and any health savings accounts you may have. According to your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances at ***the time of your visit.*** After every visit, you ***MUST check out personally and settle your account*** by check, cash or credit card. If you do not stop at check out, your account will be considered past due and a $25 fee will be assessed.

We highly recommend a credit card on file. Having a credit card on file allows flexibility for payment and can extend the time you need to pay the balance – in some cases as long as 60 days from the time of the visit. When we receive payment from your insurance company, any balance due from you will be applied to your credit card. If your credit card has expired or we are unable to run the balance through your credit card, then the balance will be billed to you via mail immediately. Your credit card information is stored in an encrypted merchant services company called Paytrace. TCFAP only has access to the last 4 digits of your account number.

Please be assured if there are financial circumstances that prevent you from settling your account at the time of your visit we are more than willing to work with you, ***but you must communicate this with our patient accounts coordinator so arrangements can be made and noted in your account.***

The adult accompanying your child is responsible for payment at the time of service unless you have a credit card on file. Unless previous arrangements have been made, adolescents who come alone should be prepared to settle their visit if you have chosen not to leave a credit card on file. In the case of non-joint custody, please note the documented guarantor is responsible for payment.

We pride ourselves on providing exceptional, state-of-the-art medical care and extended services for our patients. Sometimes insurance companies choose not to pay for recognized service codes. ***Any non-covered service is your responsibility.*** Please refer to our website for the health maintenance schedule for services provided at each visit. Most times if your insurance does not cover a service and it is your responsibility, we will offer a cash pay discount at the time of payment. Please note, after normal business hours, most insurers recognize after hour codes and we charge for these. Urgent care centers and ERs have significantly higher copays and deductibles. Please take time to understand the insurance plan you have. If your insurance does not cover these after hour codes you will be responsible.

Appointment Cancellation Policy

All specialty appointments require a 48-hour cancellation notice and primary care appointments require a 24-hour cancellation notice to avoid a fee. Depending on the complexity of the appointment, fees range from $25 to $250. There will be an automatic $25 fee for scheduled missed sick appointments if not cancelled 2 hours prior. Medicaid/Husky patients will be discharged for no-shows, as government rules prohibit this fee.

Records Release

There is no charge for releasing records if the patient is current with their yearly administrative fee. Records can by released through the portal for PSP members. If you are not current, there is a $20 fee for electronic records on disc or you may pay the state-mandated per page fee for a hard copy of the medical records.

Non-Payment Policy and Overdue Accounts

We realize some families from time to time experience financial difficulties and we want to always be here to care for your children. Communicating any hardships with us ensures uninterrupted medical care. It is of utmost importance to discuss these issues and make financial arrangements with our patient accounts' manager. However, if you ignore or fail to respond to your financial obligation, we will have no choice but to enforce our non-payment policy.

If your credit card is not valid, we will notify you and payment will be expected 10 days from receipt. If payment is not received in 10 days, a monthly billing fee of $25 will be applied. You **MUST check out personally and settle your account at each visit.** If you do not stop at check out, your account will be considered past due and a $25 fee will be assessed. As with an invalid credit card, you will receive a letter and payment is due within 10 business days from receipt. If payment is not received in 10 days, a monthly $25 billing fee will be applied.

Any accounts over 45 days will receive a certified letter and will need to be settled in 7 business days. If payment is not received or arrangements made, we will assume you no longer want to have your children seen at TCFAP. Your account will be sent to collection, and all legal fees and collection expense will be added to your balance. By law, we will continue to provide emergency care for 30 days from date of notice. Should a patient need non-emergent medical attention in those 30 days, you will be required to settle your account prior to the visit.

Yearly Administrative Fee

The modest annual fee of $40 for 18 years and under and $20 for 19 and over*, is for non-covered and administrative services. Payment of this fee entitles the patient to participate in all the services provided by TCFAP. Many of these services are administrated through our Patient Service Plan. Please visit **www.TCFAP.com** for information about our Patient Service Plan and to access the on-line Patient Portal. If you are experiencing financial difficulties or have any additional questions, please call 203-229-2040 ext. 2085.

**If you participate in Medicaid/Husky Insurance plans please contact portalsupport@tcfap.com or 203-229-2000 for PSP enrollment.*

The Center for Advanced Pediatrics
FINANCIAL POLICY SIGNATURE PAGE

Please complete and return by mail or bring to the front desk.

Guarantor's Name: _____

Guarantor's Email: _____

Patient Names: _____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Financial Policy

I have read and understand the office financial policy and agree to comply and accept the responsibility for any payment that becomes due as outlined on Financial Policy Page.

X _____ Date:_____

Guarantor Signature

Credit Card on File Policy

For your convenience we accept debit cards and credit cards (Visa, MasterCard, Discover)

(Please print name) _____authorizes The Center for Advanced Pediatrics to charge my credit card for the following reasons: *Office visits, Deductibles, Coinsurances, Copays, Non-Covered Services, Administrative Services, Cancellations and No Show Fees.*

NOTE: If the credit card you are using for the Patient Service Plan payment is NOT the card you would like saved on file for co-payments, balances or any other charge, please give the staff your preferred card.

X _____ Date:_____

Guarantor Signature

Yearly Administrative Fee

I have read, understand and agree to the yearly administrative fee. I authorize The Center for Advanced Pediatrics to charge this mandatory administrative fee to my credit card. This card will be saved on file for the year. I understand it is a $40.00/patient for 18 and under and $20/patient 19 and over. I understand that if I do not provide a credit card, I will pay the mandatory administrative fee either online or mail it to the Norwalk office at 40 Cross Street, Norwalk, CT 06851.

X _____ Date:_____

Guarantor Signature

Permission to Treat

I _____(or my legal guardian or parents) authorize The Center for Advanced Pediatrics to provide medical care reasonable by today's standards.

X _____ Date:_____

Parent/Guardian Signature