Peacock Pediatrics

An Affiliate of Children's Mercy

PROUDLY PROVIDING PERSONALIZED CARE FOR CHILDREN OF EVERY AGE AND EVERY STAGE

Financial Policy

Peacock Pediatrics believes in providing and maintaining a positive and communicative relationship with our families. Please read our financial policy carefully. We will be happy to provide further clarification if necessary.

1. Demographic & Insurance Information

- It is your responsibility to provide our office with any address, contact (phone or email), insurance changes or other updates. Failure to provide timely, updated information could result in denied charges or inability to bill.
- Please bring your insurance card to each visit in order for us to bill your insurance for you. We participate in many insurance plans and even with the same insurance company, there are many versions of coverage. It is your responsibility to understand your insurance policy and coverage. We will do our best to answer questions concerning billing, but you remain responsible to know what procedures and visits are covered. While many insurance plans cover preventative care in full, additional services may be rendered on preventative visits resulting in additional charges and may require a co-pay. If you have any questions about what is included in a preventative visit, ask one of our staff members. We are happy to help if we can.
- Co-payments, applicable deductibles, co-insurance, and self-pay fees are due at the time of your visit.
- Peacock Pediatrics will accommodate joint custody arrangements; however, the guarantor will be responsible for working with the co-parent for all financial arrangements. Separate billing will not be accommodated.

2. Billing/Payment Policy

- As of July 1, 2023, we require a valid payment card on file. A payment card is considered one of the following cards: debit, credit, FSA, HSA or HRA. Please be assured your payment card information is stored by a secure payment processor that partners with Peacock Pediatrics. Your credit card number(s) will be encrypted, and we will only have access to the last 4 digits of your card. For your convenience, we can bill co-pays and patient balances directly with this card.
- After each visit, we will file a claim with your insurance company for services provided by Peacock Pediatrics. Your insurance company is required to provide you with an EOB (Explanation of Benefits) explaining your responsibility after they have processed our claim. After reviewing your EOB if you believe there is a processing mistake, please speak with our billing department immediately.
- A 'patient balance' is triggered after your insurance has processed all claim information or your claim has been considered "self-pay". Parent(s)/Guardian(s) will be informed and responsible for any unpaid balances.
- If you are unable to settle your account in full, payment plan options can be discussed with you. Please visit the www.instamed.com link on your statement or contact our office to assist in setting up payment arrangements.
- Billing statements will be sent as a courtesy for patient balances notifications. Text, email, or portal notifications will be sent before processing your card on file. A receipt will be made available upon request.
- If you decide not to leave a payment card on file, you will be *required* to leave a $150.00 deposit for each child rendering service. Each visit you may be asked to replenish your deposit to the $150.00 balance.
- If your card on file is soon to *expire*, you will be responsible for updating your payment method via the portal, Instamed or by contacting our office.
- If a payment plan defaults, you will receive a communication via email from Instamed and will be required to update your payment method through your Instamed Portal. If your card on file declines a second or consecutive times thereafter for your payment plan, a charge of $50.00 for each transaction may be applied to your account and your account may be subject to our external collection's agency. At any time, a card is not updated in a timely manner, you may receive a communication directly from Peacock Pediatrics.

3. Non-Payment and Overdue Accounts

- We realize some families experience financial difficulties, and our main concern is providing excellent uninterrupted care for your child(ren). We believe that communication of these difficulties is of the utmost importance. Please notify our

office if you need help with financial arrangements. If you ignore or fail to meet your financial obligations, we will have no choice but to enforce our non-payment policy.

- Any account at or over 60 days old will receive a non-payment communication via letter, text, phone, or portal. All accounts will need to be settled and/or addressed before it reaches 90 days outstanding. If this notice is ignored, we will assume you no longer want your child(ren) to be cared for by Peacock Pediatrics and your account will be sent to our collections team.
- If your account is sent to collections, we will have no choice but to end our relationship as your health care provider. This includes all children listed under that financial guarantor. All upcoming preventative care appointments will be cancelled. Your child(ren) will be seen for 30 days for emergent visits only to allow you time to find another physician.

By initialing below, I agree to the following:

_____ **FINANCIAL RESPONSIBILITY:** I accept full and complete financial responsibility for all medical services rendered to the registered patient(s) and agree to all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies. I agree to pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan.

_____ **ASSIGNMENT OF INSURANCE BENEFITS:** I hereby request and authorize that all insurance benefits due and payable for medical services rendered to the patient(s) be paid directly to Peacock Pediatrics.

_____ **COLLECTIONS/DISCHARGE:** I acknowledge, understand, and agree, that if I fail to make such payments in accordance with the payment policies of Peacock Pediatrics, or in the event of default of my financial obligation to pay for services rendered, Peacock Pediatrics may terminate the doctor-patient relationship with all patients associated with the financial guarantor. Furthermore, in the event of my default on my financial obligations, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection cost.

_____ **COMMUNICATION:** I hereby expressly consent to Peacock Pediatrics, or its billing and collection agent(s) to contact me using electronic media to include cell phone, automated messaging, text messaging, voicemails, portal, and email.

_____ **SELF PAY:** I understand that in the event the patient is not covered by a medical insurance plan, I will be offered two options and considered "self-pay". Option one will be to pay the full amount of the visit charges less a 40% discount at the time of the visit. Option two will require a payment deposit of $150.00 at the time of visit before any medical care is rendered. I understand that the payment of the deposit represents only a partial payment of the total fees that may be charged for the medical service to be rendered, and that I will receive a statement for the total charges incurred with no discount applied. I understand that this balance must be paid in full at or before the next visit.

_____ **RELEASE OF MEDICAL RECORD INFORMATION:** I hereby authorize Peacock Pediatrics to disclose all or any part or the contents of the medical record of the patient(s) named on this form to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal HIPAA regulations. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

Our goal is to care for your children. Our billing team is happy to help you with any questions you may have regarding your balance at (816) 396-6026. We would like to thank you for choosing Peacock Pediatrics. We are committed to providing the best possible care for your child(ren).

By my signature below, I state that I have read and understand the Financial Policy for Peacock Pediatrics.

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Patient Name: _____ **DOB:** _____

Signature of Guarantor: _____ **Guarantor SSN:** ___-___-____

Printed Name of Guarantor: _____ **Date:** _____

Relationship to child: ☐ **Parent** ☐ **Legal Guardian** ☐ **Foster Parent** ☐ **Healthcare Power of Attorney**
☐ **Other:** _____