Children's
of Alabama

Vestavia Pediatrics
1936 Old Orchard Road
Birmingham, Alabama 35216
205-978-3200

Vestavia Pediatrics Financial Policy

Thank you for choosing Vestavia Pediatrics as a health care provider for your child. It is a privilege for us to participate in his/her medical care. We hope that your experience with our clinic will be a pleasant one as we work together to meet the medical needs of your child. As you know, in order to continue to provide the proper level of medical care, prompt payment of the charges for our service is essential. To help clarify our billing procedure, the Vestavia Pediatrics Financial Policy is outlined below:

1) **Payment is due in full at the time of service unless you are covered by one of our contracted insurance carriers.** If not paid in full, a $10.00 billing fee will be added. Patients who are covered by a private insurance carrier will be provided with the paperwork necessary for you to file for your reimbursement.
2) If you are covered by one of our contracted insurance carriers**, all co-pays are due at the time of service. If co-pays are not paid at the time of service a $10.00 billing fee will be added.**
3) We will file for reimbursement from your insurance carrier if you are covered by one of our contracted carriers. It is your responsibility to provide us with the correct insurance information and to be familiar with your particular coverage and benefits. Unpaid claims will be re-filed one time and if they remain unpaid will become your responsibility.
4) All claims that are denied by your insurance carrier will be your responsibility.
5) **We are sorry that we cannot accept divorce decrees as assignment of responsibility for your child's medical bills**. As stated above all co-pays or deductibles are due at the time of service. It will be your responsibility to seek reimbursement from the party named in your divorce decree as the responsible party.
6) The person named as guarantor on our Patient Information sheet should be the person who completes and signs this financial agreement and will be the person billed for any unpaid charges. All unpaid balances will be subject to interest charges being added, if not paid in a timely manner.
7) We realize that there are circumstances and events that make the payment at time of service difficult or impossible. When these situations arise, we will be happy to work out a payment plan with you. Please, contact our Patient Financial Advocate as soon as possible, when these circumstances arrive, so that we can work with you toward establishing an adequate payment plan.
8) **A $25 charge will be assessed to your account if appointments are not kept or rescheduled 24 hours in advance of appointment time.**
9) I give consent to pull information from Prescription Benefit Manager.
10) Vestavia Pediatrics, and its assignees, may contact me at any telephone number or email address I provide, including wireless numbers; send text messages or emails to any number provided; leave voice mails at any number provided, to relay information regarding treatment or financial information, including debt collection; may use technology like pre-recorded/artificial voice messages and/or an automatic dialing device in connection with any communications regarding this account. You accept there may be a risk that the messages may be unencrypted, intercepted, and could be read by a third party.

This Financial Policy has been set forth as part of an overall effort to provide your child the best possible medical care. We thank you for entrusting us with the medical care of your child.

I have read, understand and agree to the provisions of this Financial Policy. I authorize release of my child's medical records to my insurance carrier. I understand that I am responsible for all charges and fees accrued on this account and that if this account is referred to a collection agency, I will pay all fees associated with collection.

Please list the patient(s) names below:

_____ _____ _____

_____ _____
Guarantor Signature **Date**

_____
E-mail Address and cell phone number for billing purposes

Consent to Discuss Financial Information

Please list below anyone with whom we have your permission to discuss the financial information included in this account. If we do not have your permission we will not discuss financial information with anyone other than the person responsible for the account.

_____ _____
Name **Relationship to Patient**

_____ _____
Name **Relationship to Patient**

_____ _____
Guarantor Signature **Date**

Updated 08/2018