Billing Agreement Effective January 1, 2018

Estrella Pediatrics' providers and staff want to focus all their time and efforts on quality patient care. Unfortunately, due to all the changes with insurance carriers and high costs associated with billing, Estrella Pediatrics has had to implement a new billing policy. Please read this form in its entirety, initial and sign where indicated and provide the information on the back of this form.

____ **Required payments:** Any co-payments required by an insurance company must be paid at the time of service. There is an additional charge of $10.00 for each copay billed. ☐

____ **Deductible Plans:** All deductible plan patients will be required to pay a $50 deposit for each applicable visit per child. Multiple items play a role in how much an office visit will cost. Office visit costs may increase based upon the visit complexity, labs done in office, and treatments given. If the cost of the visit is more than the deposit amount, a statement will be sent. You may also choose to sign the easy pay consent form on the back in lieu of paying the visit up front.

____ **Monthly Statements:** If you have a balance on your account, we will send you a monthly statement. Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

____ **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, there will be a $25 surcharge fee imposed on your account and you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all of the lawyer's fees which we incur plus all our court costs. In case of suit, you agree the venue shall be in Phoenix, Arizona.

____ **Missed appointment fee:** Patients who do not show up on time for an appointment, or cancel with less than 24 hours' notice will be charged a $25 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments will be asked to transfer their records to another doctor.

____ **Returned checks:** There is a fee (currently $25) for any checks returned by the bank. NSF checks must be redeemed with certified funds (money order, certified check, or cash.) You will no longer be able to make payments on your account with a check; instead future payments will need to be cash or credit only.

____ **Visits:** The provider is required to code the visit based on all care provided and if an abnormality is encountered or a preexisting problem is addressed in the process of performing a preventive exam, and/if the abnormality/problem is significant enough to require additional work (either during the visit or after), then separate billing for a problem visit may occur. With this in mind, while the appointment may have been scheduled for just a preventative exam or just for a problem(s), if both types of services are provided during the exam then both types of services may be billed. We cannot change the coding after it has been submitted to your insurance company in order for them to pay non-covered services.

____ **Third Party Vendors:** Cost for any labs, diagnostic testing, durable medical equipment or treatments done outside of our office are patient's responsibility. These costs are not associated with Estrella Pediatrics. This includes labs that are sent out from our office to the laboratory or durable medical equipment provided in our office on behalf of the vendor. These services are billed to your insurance directly by the third party.

Printed Name: _____ Relationship to patient _____

Signature: _____ Date_____

Patient Name: _____ Last Name	_____ First Name	_____ Date of Birth
Patient Name: _____ Last Name	_____ First Name	_____ Date of Birth
Patient Name: _____ Last Name	_____ First Name	_____ Date of Birth
Patient Name: _____ Last Name	_____ First Name	_____ Date of Birth

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PATIENT EASY PAY CONSENT FORM

Patient Name: _____ _____ ____ _____
Last Name First Name M.I. Date of Birth

Patient Name: _____ _____ ____ _____
Last Name First Name M.I. Date of Birth

Patient Name: _____ _____ ____ _____
Last Name First Name M.I. Date of Birth

Patient Name: _____ _____ ____ _____
Last Name First Name M.I. Date of Birth

I authorize Estrella Pediatrics, P.C. to charge my payment card for the balance of fees determined as member responsibility by my insurance carrier:

□ All visits from ____/____/_____ to ____/____/_____ (90 day minimum), not to exceed a charge of $100 per child, per visit.

□ Indefinitely, not to exceed $100 charge per child, per visit.

If the cost of the visit is more than $100, a statement will be sent for the remaining balance.

I choose to have a receipt: □ mailed to the address on file
□ emailed to the following address: _____

_____ _____
Card Holder Name Card Holder Signature

_____ _____ _____
Credit Card Number Card Expiration Date CVV (3 or 4 digits)

I assign my insurance benefits to the provider listed above. I understand this form is valid unless I cancel the authorization through written notice to the health care provider.

Printed Name: _____ Relationship to patient _____

Signature: _____ Date_____