



3650 Joseph Siewick Drive, Suite 101, Fairfax, Virginia 22033

6211 Centreville Rd, Suite 100, Centreville, VA 20121

703-391-0900

**FINANCIAL POLICY 2010**

We are committed to providing you with the best possible care and helping you receive maximum insurance benefits. You need to **understand your insurance coverage: not all services are covered by all plans and we do not know the details of all insurance plans.** While the filing of insurance claims to insurers that we participate with is a service that we extend to our patients, all fees **ARE** ultimately the patient’s responsibility. We accept assignment from most major insurance carriers; which means covered charges will be paid directly to us. We file secondary insurance with FPA participating insurance carriers only. Newborns must be added to your insurance policy within the first 30 days of life otherwise you may not be able to enroll your child until the next open season. You will be held responsible for all services provided to your child, with or without insurance benefits.

If we do not participate with your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance company. However, payment is expected at the time service is rendered.

Due to current federal and insurance regulations, all co-payments, co-insurance and deductibles are collected at the time of service. We accept cash, checks, MasterCard, and Visa. The following criteria must be met prior to issuing a patient refund: there are no outstanding insurance claims on the family’s account, and there are not outstanding patient balances on the family’s account.

If both parents have insurance coverage, the primary insurance carrier is determined by “The Birthday Rule”. Whichever parent’s birthday falls earlier in the year is the holder of the primary insurance; the other parent retains secondary coverage. The parent with primary custody is usually the parent with whom the child resides and the parent who usually brings the child to FPA for care. The custodial parent is responsible for payment to FPA.

If your insurance requires you to designate a primary care physician (PCP), you are required to have authorization from us, your PCP, **PRIOR** to having a specialist appointment. We require 5-7 working days for routine referrals to be processed. Emergency referrals will be handled on a case to case basis. Do not call us from the specialists’ office to request a referral. You may have to reschedule your appointment or self-refer, and pay the specialist’s fees at the time of your visit. It is the parents’ responsibility to be aware of the services needing insurance pre-authorization and requesting same from FPA.

Payment plans are extended to families with financial needs. Each agreement is unique and personalized to each family’s situation and is arranged through our billing office. Any account that requires FPA to initiate collection actions will have the collection agency’s fee added to the balance the parent owes FPA.

**WE ENCOURAGE YOU TO CONTACT OUR BILLING OFFICE PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT. 703-391-0900**

FPA is not active or participating with Tricare. FPA will not file claims, NOR should you file claims for reimbursement.

Additional Fees:

- \$25.00 – Co-payments not paid within 24 hours of service.
- \$50.00 - Checks returned by your bank.
- \$25.00 - Missed Nursing Appointment
- \$50.00 - Missed Sick Appointment, not cancelled within 2 hours
- \$100.00 - Missed Well Examination, not cancelled within 24 hours
- \$5.00 - Medication Refills, not refilled at time of visit
- \$5.00 - Monthly payment plan service fee
- \$10.00 - Form Completion Fee (each)
- \$30.00 - -Form Completion Rush Fee
- \$25.00 - Letter requests
- \$15.00 - After hours advice phone calls
- Collection Agency Fees
- Copies of Medical Records

**PATIENT FINANCIAL AGREEMENT**

I hereby authorize Fairfax Pediatric Associates, P.C. to apply for benefits on my behalf for all services rendered. I certify the information I have provided with regard to my insurance coverage is correct. I further authorize the release of any and all information necessary for my insurance company to determine benefits for services rendered. I request payment of authorized benefits be made payable to Fairfax Pediatric Associates, P.C. on my behalf.

I understand and agree regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I have read the above Financial Policy and have provided FPA with true and correct insurance information. I will notify FPA of any changes in my health insurance coverage.

A copy of this may be used in place of the original.

Signature of Patient, Policy Holder or Legal Guardian

Date

Printed Name: \_\_\_\_\_

Account number: