San Fernando Pediatrics & Urgent Care

107 N Maclay Ave, San Fernando, CA 91340
Tel: (818) 697-8585 Fax: (888) 799-8585

Financial Policy

San Fernando Pediatrics & Urgent Care participates with most insurance plans. Each insurance policy is different and it is therefore impossible for us to know what are your particular benefits may be. Therefore it's important to contact your insurance company if you have any questions regarding your benefits and for you to know what your payment obligations will be at the time of service.

Copayments and Deductibles

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of service. Payment may be made in cash, or by credit or debit card. We also accept Health Savings Account (HSA) cards for payment.

Please note that your co-payment is a contractual requirement from the insurance company and cannot be written off by the clinic. If you participate in a High Deductible Health Plan (HDHP) and have not yet paid or met your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. We are happy to discuss arrangements for payment by installment if you need to do so.

Please ensure that if you are unable to bring your child in by yourself, whomever brings the child, is prepared to make all payments.

Credit Card on File[1]

In order to make sure that we can collect your portion of the bill once your insurance company processes the claim, it is our policy to have a valid credit card secured on file with the practice. Your card will only be charged the outstanding amount that your insurance company determines to be 'patient responsibility', as spelled out in your Explanation Of Benefits (EOB). Once your card is charged, a receipt may be sent to you by email or text to your mobile phone.

If you would like to make arrangements to pay the amount by installments, please notify the office in advance.

[1] **This policy does not apply to patients with Medicaid and Medicaid HMO insurance**

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Patients Without Insurance Coverage

We are happy to work with families that prefer to pay directly for services or do not have insurance. For such patients, a time of service discount will be applied to the bill if settled in full on the day of service. This discount does not apply after the day of the visit.

Administrative Fee

At San Fernando Pediatrics & Urgent Care, coordination of care is central to making sure that children get good quality healthcare. This means several hours are spent providing services that insurance does not pay for. Some of these services include processing various administrative requests, handling refill requests outside of office visits, providing after hours calls to parents, performing phone consultation with other pediatric specialists, securing medical records from other providers, providing a patient portal and filling any forms needed for school or camp without charging a fee for each form. To cover that administration, we charge a small annual fee of **$40 per child up to a maximum of $100 per family.**

You may choose to opt out of the annual administrative fee and pay a-la-carte for these requests instead. A **$50 fee** will need to be charged for each request, including any school entry, annual school physical, sports and camp physical forms.

No-Show & Same-Day Cancelation Fee

Missing an appointment without giving prior notice to the practice deprives other patients of the chance to take a slot that opens up. We require notice of **at least 1 business day** for all cancellations. Failure to notify the clinic in a timely manner will result in a no show fee of **$50** per individual patient appointment. Repeated no-shows will result in the family being advised to transfer care out of the practice.

I have read, understood and agree with the above financial policies.

Signature: _____ Date ___/___/_____

Name: _____

Relationship to patient: _____

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Patient Financial Responsibility

I hereby authorize San Fernando Pediatrics & Urgent Care to file a claim to my insurance on my behalf for covered services rendered by the practice. I also assign my benefits and request that all payments from _____ (insert insurance company) be made directly to San Fernando Pediatrics & Urgent Care. The foregoing insurance company is the (circle one) primary / secondary insurance for me.

If the foregoing insurance company is the secondary insurance, the primary insurance company is _____ (insert insurance) company.

I agree to assume responsibility of full payment as allowed by applicable laws, in the event that:

- ☑ My insurer or self-funded employer does not pay the claim in a timely and accurate manner; or
- ☑ The insurer or payer deems the service to be either not medically necessary or to be an excluded or non-covered service; or
- ☑ A claim is prospectively or retroactively denied due to lack of eligibility for benefits.

I certify that the information I have reported with regard to my coverage is accurate.

I authorize San Fernando Pediatrics & Urgent Care to release to said insurance company and its agents, any information related to any claim.

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Name: _____

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Administrative Fee Form

Patient Name: _____ DOB: ____/____/_____

Please select ONE

☐ Please charge the annual Administrative Fee of $40 per child (up to a maximum of $100 for my family).

☐ Please do NOT charge the annual Administrative Fee of $40 per child (up to a maximum of $100 for my family). I prefer to pay a-la-carte for services covered by the fee and understand that a $50 fee will need to be charged for each request, including any school entry, annual school physical, sports and camp physical forms and prescription refill requests made when the patient is not in the office.

I understand that I may switch my preference to the annual fee prior to incurring the first charge.

Signature: _____ Date ___/___/_____

Name: _____

Relationship to patient: _____

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Non-Covered Services Waiver

We pride ourselves on providing only the **highest quality care** for your child and do this by following many of the American Academy of Pediatrics clinical guidelines and other trusted sources for evidenced-based clinical outcome information.

However, insurers rarely keep pace with guidelines, or want to cover services related to meeting these clinical recommendations. In fact, insurance company rules and policies change all the time. As prompt and appropriate treatment of your child is of primary importance to us, we ask that you sign a 'waiver' giving us permission to perform screenings, tests and non-covered services as we, your trusted providers of care, deem necessary.

Following is a list of the most frequently provided services for which we request a signed waiver and that you can use to determine coverage with your insurer.

Vision Screening

- **Snellen Testing**. This is a simple screening performed with the use of a Snellen eye chart used to measure visual acuity on older children.

- **Visual Evoked Potential** testing (or VEP). This is an important test for early detection of eye and vision problems in infants and young children. Amblyopia (or 'lazy eye') occurs when the brain does not receive proper images from the eye. If it is not diagnosed in early childhood, there may be a permanent loss of vision in the affected eye.

  As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount.

  For Snellen tests the discounted price is only $15.00, and for VEP tests the discounted price is $30.00.

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Otoacoustic Emissions Testing (or OAE)

This is an important hearing test and can be used on newborns through adulthood. It does not require a soundproof room or the ability of the child to understand instructions or respond to sounds, which makes it a much more accurate screening tool for picking up on hearing issues at any age.

Not only do we believe that hearing screens should be performed every year, but testing is required for most preschools, public and private schools, and for sports. As we consider this to be an important test for your child, and will routinely perform it at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $15.00 per test.

Developmental Testing

Developmental screening (including standard pediatric developmental screening done at well-visits, Connors forms, Edinburgh post-partum depression screening, etc) are very important in the assessment of any development delays or potential problems. As we consider these to be important tests for your child, and will routinely perform them at annual well visits, if your insurer does not cover the charge, we will significantly discount the amount to $10.00 per test.

Ear Piercing

In addition to screenings and lab test, we also offer ear piercing which is not a covered service by your insurance company. We charge $60.00 including a pair of studs.

Please sign the following waiver indicating that you are aware that these charges may apply in the event that your insurance company does not cover these services.

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In-office lab tests

Often, patients want to know as soon as possible if their child has the flu, strep, etc. We can effectively and efficiently determine that by performing in-office testing. Many insurers do not pay for in-office testing because they have contracts with external labs to provide these services. However, sending tests out to external labs results in waiting days for results that we can provide to you much more quickly (in some cases, within minutes or overnight). We believe it is important to treat your child as quickly as possible, and therefore offer these services in-office.

In-office labs and fees include:

In-office Test	Fee
RSV Test	$35.00
Rapid Flu	$25.00
Rapid Strep	$25.00
Urinalysis	$25.00
Pregnancy Test	$25.00

Waiver Form Acknowledgement of Receipt

I acknowledge receipt of the Waiver List and have been informed of, and hereby attest that I fully understand my financial responsibility for any balance resulting from non-covered services, or services not covered in-office, by my insurer. I agree to pay the amount of the charge as stated herein, in the event that my insurer does pay for these services.

Signature: _____ Date ___/___/_____

Name: _____

Relationship to patient: _____

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ASSIGNMENT OF BENEFITS FORM

All professional services rendered are charged to the patient and are due at the time of service, unless insurance coverage is verified and San Fernando Pediatrics & Urgent Care is a participating provider. Necessary forms will be completed to file for insurance carrier payments.

Assignment of Benefits
I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to San Fernando Pediatrics & Urgent Care for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Authorization to Release Information
I hereby authorize San Fernando Pediatrics & Urgent Care to: (1) release any information necessary to insurance carriers regarding myself and/or my dependent's illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from San Fernando Pediatrics & Urgent Care on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges (copay, coinsurance and/or deductible) incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date ___/___/_____
Name: _____
Relationship to patient: _____