Children's Medical Group of Austin, PLLC
Financial Policy

Our office strives to provide and maintain good physician-patient relationships. To reduce confusion and misunderstandings, we have adopted a clear financial policy. Please discuss any questions you may have regarding these policies with our office manager. We provide our best care and service to you and regard your complete understanding of our financial responsibilities as an essential element of your care and treatment.

-Unless either you or your health insurance carrier have made other arrangements in advance, full payment is due at the time of service. For your convenience, we accept cash, VISA, MasterCard and Discover.
-It is our policy to add an additional $10.00 late fee to the balance owed every 30 days if it is not paid in full from the statement date, or unless payment arrangements are made.
-Unpaid balances over 90 days will be turned to collections and will incur an additional 20% service fee to the outstanding balance.
-If accepted as a private pay patient by Children's Medical Group, you will be responsible for paying for any services you receive at the time of service. We will not file a claim to Medicaid for these services as we do not take assignment from Medicaid.

Your insurance

-We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we bill those plans for which we have an agreement and will only require that you pay the authorized co-payment or deductible at the time of service.
-If you have insurance coverage with a plan for which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis; however, full payment is required from you at the time of service.
-In the event your health plan determines a service to be "not covered," you will be responsible for paying the complete charge. Payment is due upon receipt of a statement from our office.
-All HMO plans require that you assign a Primary Care Physician. It is your responsibility to ensure that your CMG physician is correctly listed as your physician prior to your office visit. Otherwise, you will be responsible for the charges from any services performed.
-Insurance has changed the way that we must bill to receive compensation for our range of services. Wellness Child visits are for addressing growth, development, vision, hearing, safety and to administer vaccines. New problems take time to address and diagnose. It is our policy to address you and your child's concerns while you are in the office if possible. If we address any problems during a Wellness Check, you will be charged for an additional acute visit that may require a visit co-pay for the additional care that you receive that day. The benefit is that you will not need to schedule an additional visit to address the problems. Please note that to address complex, chronic problems such as ADHD, behavioral concerns, asthma, ongoing complaints, we may need to schedule a follow up visit as these are very important topics that require special time.

Minor patients

-For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Forms

-Forms for sports, camp, daycare, therapy, 504/IEP, printed and signed vaccine records will incur a separate charge.
-To receive a completed form within 5-7 business days, a charge of $15 for each child's form will be placed on your account.
-To receive a completed form within 2-3 business days, a charge of $30 for each child's form will be placed on your account.

Cancellation Policy

A charge of $50 will be incurred for Wellness Checks cancelled with less than 24 hours' notice (during business hours).
A charge of $50 will be incurred for same day acute visits with less than 3 hours' notice.
We make a great effort to see our sick patients in a timely fashion and no shows and late cancellations take up a time that could be filled with a sick child.

I have read and understand the Financial Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____
Printed Name of the Patient

_____ _____
Signature of Patient or responsible Party if a Minor Date

1912 W. 35th Street Austin, TX 78703 / p 512-451-5161 / f 512-451-1258 / www.cmgaustin.com