Zarminali Pediatrics Billing & Collection Policy

Please read the following information regarding Sartell Pediatrics' billing and collection procedures and payment expectations. Note that when we use the term "you," "your," or similar terms in this document, we are referring to the patient and/or the person who is responsible for paying for the patient's health care, as applicable. If you have any questions about this policy, please contact your local practice.

Insurance. If you are covered by an insurance plan that we accept, we will bill your insurance plan for the health care services we provide to you based on the insurance information that you provide to us. We accept many insurance plans, but we cannot guarantee that your insurance plan will cover our services. Prior to receiving services, the practice will be verifying the coverage of your insurance plan and complying with any coverage-related requirements. We will check your insurance eligibility and demographics. If requested, you must present your insurance card and identification information at check-in. If you do not have insurance coverage, we will discuss payment options with you.

Referrals. If your insurance plan requires a referral for you to receive our health care services, you must get the required referral before you are seen at our facility. Failure to get a required referral could reduce your insurance benefit or leave you responsible for the total charges.

Co-Payments, Deductibles, and Other Amounts Not Covered by Insurance. You are responsible for any amounts not paid by insurance. This includes co-payments, deductibles, non- covered services, and any other amounts not covered by insurance. Co-payments are due at the time of your visit.

Newborn Policy: Subject to state and federal law, it is your responsibility to add your newborn child to your insurance policy within 30 days of their birth. If you are unable to provide Zarminali Pediatrics with active insurance within that time, you understand that you will be billed directly for any services rendered. **Once your child's insurance is activated, you will need to your local practice to ensure that previous claims can be submitted and/or to make payments on your child's account.** If your account becomes Past Due, the above Past Due policy will apply.

Service Fees: Subject to state laws, your account will be charged $50 for NSF/Returned checks.

Statements and Payment Terms. We send billing statements to the patient or responsible person monthly following the initial correspondence we receive from your insurance company. After your insurance company has paid or identified its portion of the bill, the remaining balance is your responsibility and should be paid within thirty-days (30) of the statement date. If you are unable to pay the amount due by the due date, please contact our business office to set up an acceptable payment plan.

Billing Error Review. If you believe that your bill is not accurate, that a third party should pay the bill, or if you have other concerns about your bill, please contact our business office to discuss the matter. If you notify us of a billing error, or we otherwise determine that there is a billing error, we will review the bill and correct any billing errors found. While the review is being conducted, we will not bill you for the health treatment or services that are the subject of the review for potential billing errors. We may resume billing you for the health treatment and services that were reviewed for potential billing errors only after (a) the review is complete, (b) any billing errors are corrected, and (c) a notice of completed review (as detailed below) is transmitted to you. If, after completing the review and correcting any billing errors, we determine you overpaid us under the bill, we will refund the amount overpaid under the bill within 30 days after completing the review.

Required Error Review Notices. Within 30 days of our determining or receiving notice that your bill may contain one or more billing errors, we will notify you (1) of the potential billing error; (2) that we will review the bill and correct any billing errors found; and (3) that while the review is being conducted, we will not bill you for any health treatment or service subject to review for potential billing errors. Within 30 days after we complete this review, we will (1) notify you that the review is complete, (2) explain in detail (a) how any identified billing errors were corrected, or (b) if applicable, why we did not modify the bill as requested, and (3) include applicable coding guidelines,

references to health records, and other relevant information. This information will be sent to you via regular mail and your patient portal account, if applicable.

Medical Debt Owed and Collection. We will send you statements identifying your remaining balance from time to time. If you are having difficulty paying your balance, we encourage you to contact our business office about your account. Our business office staff will help you with questions and concerns, and work with you on a payment plan and other reasonable options to help you pay your balance.

Referral to a Collection Agency or Law Firm. We may use a collection agency or law firm in certain cases where the terms of a payment arrangement or terms of our billing and collection policy have not been met. If you have not paid the balance due within 94 days of the applicable statement date and have not made acceptable payment arrangements with our business office, or have not complied with agreed upon payment arrangements, we may refer your account to a collection agency or law firm. Your medical debt will not be reported by us to a consumer reporting agency or credit bureau.

Ending Collection Activities. We review accounts periodically to confirm the status of any debts, and to identify uncollectible and satisfied debts. We will end collection activities once a debt is identified as satisfied or uncollectable, in accordance with our arrangement with the applicable collection agency or law firm. Our business office staff will provide updates regarding the status of your account upon your request.

Outstanding Debt. We will not deny medically necessary health treatment or services to you or any member of your family or household because of current or previous outstanding medical debt owed by you or any member of your family or household to us, regardless of whether the health treatment or service may be available from another health care provider. As a condition of providing medically necessary health treatment or services when you or any member of your family or household has current or previous outstanding medical debt to us, we may require you to enroll in a payment plan for the outstanding medical debt owed to us. The payment plan will take into account any information you disclose to us regarding your ability to pay. If you are unable to make all or part of the agreed-upon installment payments under any such payment plan, you must communicate your situation us and you must pay an amount you can afford. We may seek other legally permitted remedies in the event of your failure to abide by the payment plan terms.

Legal Requirements. When collecting medical debt, we will comply with all applicable requirements of law.

Contact. If you have any questions about this policy or our billing and collection process, please contact your local practice.

Patient Name: _____	Patient DOB: _____
Patient Name: _____	Patient DOB: _____
Patient Name: _____	Patient DOB: _____
Patient Name: _____	Patient DOB: _____
Patient Name: _____	Patient DOB: _____

_____ _____

Patient or Parent/Guardian Signature Date

Addendum for Michigan patients

Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good-faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

I have received, read, and understand this disclosure.

Patient or patient's representative's signature:_____

Date:_____