200 BEAULLIEU DR, BLDG 7 LAFAYETTE LA 70508 337.366.8616
WWW.LAPETITEPEDS.COM

FINANCIAL POLICY

Insurance:

As a courtesy, our office will file the forms necessary so that you receive the full benefits of your medical coverage. We ask that you familiar with your insurance policy to be fully aware of any limitations of the benefits provided. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Insurance is a contract between you and your insurance company and/or your employer and your insurance company. Although our office will make a good faith effort to assist you in obtaining your benefits, it's at the discretion of your insurance company to pay for the services we have provided to you.

Copayments and Deductibles:

A copayment and/or deductible or coinsurance may be required at the time of service depending on your insurance policy. Payments are accepted in the form of cash, by check or by credit card with a courtesy fee of 4%. We also accept Health Savings Account (HSA) cards for payment.

Copayments are a contractual requirement from the insurance company and cannot be written off by our office. If you have a High Deductible Health Plan (HDHP) and have not yet paid your deductible in full, it is likely that any non-preventive services will require payment at the time those services are rendered. Coinsurance may apply even after meeting your deductible. Please see "Health Insurance 101" for a better explanation of these terms.

Patients Without Insurance Coverage/Non-Covered Expenses:
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 only applies the day of service. The same discount will be applied to any non- covered charges for patients with insurance, if paid at the time of service. This discount cannot be applied toward the "patient responsibility" portion of covered charges, as those charges are already discounted through the contract we maintain with your insurer.

Financial Arrangements:
We provide a variety of payment options. For your convenience, we accept all major credit cards and checks. Credit card payments are subject to an additional 4% convenience fee and returned checks will be subject to a $35 returned check fee. If the check is returned for any reason, you will have 7 days to contact our office and arrange another form of payment.

Sick Complaints at a Wellness visit:

Insurance covers preventive care (wellness visits) as a bundled service. If you present to a scheduled wellness visit and your child is sick, or you'd like to address a chronic issue, our office is obligated to file a separate visit code with your insurance plan — just as we would if you brought your child in for that complaint on any other day. As

La Petite Pediatric Clinic complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. La Petite Pediatric Clinic cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-408-2431. TTY: 711.

such, your regular copay, deductible, and/or co-insurance amounts will apply, and payment will be expected at the time of service.

Appointments/Cancellations:
We gladly reserve appointment times for you and appreciate that you have chosen La Petite Pediatric Clinic for your care. As a courtesy, we will remind you of your appointment by calling and/or sending a text or email to remind you of your scheduled date and time. If we cannot speak to you directly, we will leave a message for you. However, in the event your mailbox is full, or your line is busy, our efforts to contact you may be unsuccessful. An appointment is a contract of time reserved for your treatment. We respect our patient's valuable time and we request the same courtesy from our patients. Please extend this courtesy should you need to cancel and/or reschedule your appointment. We reserve the right to charge $25 for regular appointments cancelled without advance notice of at least 1 business day. Appointments that are scheduled for the same day and then cancelled, as well as no-shows for an appointment, may be assessed a $50 charge. After three no-shows or same-day cancellations, your family may be dismissed from the practice.

Patient/Parent/Guardian Responsibility:

- I understand that whomever accompanies my child to their appointment has authorization to consent to medical care as needed and is responsible for payment of medical services.
- I acknowledge my responsibility for payment of all services provided by La Petite Pediatric Clinic in accordance with the practice's fees and terms.
- In the cases where a parenting plan exists, the parent that brings the child in for the appointment is considered the guarantor and is responsible for payment.

Late Fees:
I understand that my account becomes delinquent if not paid within 30 days after billing and the unpaid balance becomes subject to a monthly finance charge of 1.5% (18% APR) or $35, whichever is greater. Any further delinquency will warrant the balance and any administrative fees being assigned to a collection agency.

Assignment and Release:
I authorize payment to be made directly to La Petite Pediatric Clinic by my insurance company, and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical care information requested by my insurance company. My signature below acknowledges that I have read and understand this information.

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By signing below, I acknowledge that I have read and understand the financial policy as stated above and agree to the terms outlined.

Name (please print): ______________________________________ Date: _________________

Patient's Name and Birth Date:

Signature of Responsible Party (Guarantor):

____

Relationship to Patient(s) (please check): ___ Parent ____ Self _____ Other: ______________

Witness Signature:

____

Note: *The patient (or guarantor) must sign this sheet and present valid photo identification before the patient can be seen. This is for your protection and to prevent fraud.*

Notice of Privacy Practices Written Agreement:
I also acknowledge that I have read a copy of La Petite Pediatric Clinics' Notice of Privacy Practices. I understand a written copy will be provided to me at any time upon my request. I understand La Petite Pediatric Clinic has a link to the Notice of Privacy Practices on the practice website (www.lapetitepeds.com).

Name (please print): ______________________________________Date: __________________

Signature of Parent / Guardian / Patient:

____

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