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2022 PAYMENT POLICY & HIPAA ACKNOWLEDGEMENT

PAYMENT IS EXPECTED AT THE TIME OF SERVICE UNLESS PRIOR PAYMENT ARRANGEMENTS ARE MADE WITH OUR BILLING DEPARTMENT. Payment may be made by cash, check or credit card. On accounts which have established payment arrangements, the payment is due upon receipt of the monthly statement. In lieu of payment at the time of service, we can bill the following insurers or insurance plans directly:

Premera Blue Cross (Heritage/Foundation, PPO, LifeWise)	Molina Apple Health
First Choice Health Plan	Aetna
WA Medicaid (DSHS Apple Health)	United Healthcare
Cigna Healthcare	Blue Shield (Blue Card) Plans
Kaiser Permanente	Asuris

It is up to you to provide us with all information necessary to bill your insurance company. We do not guarantee payment. You will be responsible for payment of all services not covered by your insurance company. It is your responsibility to follow-up with your insurance to ensure payment is made. Known deductibles not yet satisfied are also due at time of service.

DELIQUENT ACCOUNTS: All accounts are due and payable within 30 days of services rendered. A **$25.00** returned check fee applies to any check returned by the bank. Unless a payment schedule has been arranged with the billing department, accounts left unpaid after 120 days will be turned over to an agency for collection follow-up and may result in dismissal from our practice of all children for whom you are the guarantor.

MEDICAID WAIVER: I _____ do _____ do not *(check one)* have Medicaid (DSHS) insurance coverage (either primary or secondary). If I do, I understand that if my Medicaid plan does not cover certain services provided, I am responsible for any balance due.

ACKNOWLEDGEMENT: I have read the above policy statement and understand that regardless of any insurance coverage I may have for my child(ren), I am responsible for payment of my account in a timely manner. I agree that in the event that costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees including but not limited to collection costs, attorney fees and all court costs.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment by my insurance company directly to Spokane Pediatrics for those charges as described on the billing statement.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize Spokane Pediatrics to release to my insurance company any and all information they may require concerning patient care.

HIPAA ACKNOWLEDGEMENT: I have received the Notice of Privacy Practice, and I have been provided an opportunity to review it.

I am the guarantor for the following individual(s) and for whom I give Spokane Pediatrics permission to treat:

Name: ____ DOB: ____________________________

Name: ____ DOB: ____________________________

Name: ____ DOB: ____________________________

Name: ____ DOB: ____________________________

Guarantor's Signature: ____ Date: ______________________