Updated 11/2024

Our Financial Policy

PediatriCare of Northern VA, P.C. follows both State and Federal guidelines in billing for services rendered to our patients. This requires us to obtain specific information for each individual patient in the family. We understand that the collection of this information can seem overwhelming, however, it is necessary in order to provide you more efficient service.

Please read carefully the information listed below. If you have any questions, our office staff will be happy to answer your questions. If assistance is required in resolving a billing issue, please contact the Billing Department between 9:00am and 4:30pm Monday – Friday, 703-330-3939.

1. A valid government ID is requested at the time of service from the person authorizing the health care services for the child(ren). Please note that if this right is being granted to a caregiver (i.e. nanny or grandparent) that is not the child's legal guardian, we must have written authorization from the legal guardian.
2. If there is a financial arrangement between individual parental parties concerning financial responsibility for medical care of their children, this arrangement is between the two parties and does not absolve the parent that brings the child for services from their financial obligation to our practice.
3. The parent/guardian must provide accurate demographic and insurance information prior to patient treatment. If you are covered by health insurance, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage and benefits as a courtesy. Accepting your insurance is not a guarantee of benefits or payment. You will be held accountable for any unpaid balances by your plan.
4. It is the parent/guardian's responsibility to know which benefits are not covered by the insurance program in which they participate, as the office staff does not have access to this information. Further, the parent/guardian is fully responsible for all fees that are denied as non-covered services, deductibles, coinsurance and co-payments. If the parent/guardian has questions concerning their coverage, they should contact their employer's human resource department, their insurance agent, or their insurance company directly.
5. It is the responsibility of the parent/guardian to open and read the explanation of benefits sent to them from their insurance. If they believe there has been an error in processing their claim, they need to call the insurance company directly. PediatriCare of Northern VA's billing department will be happy to assist in getting the claim resolved.
6. Based on PediatriCare of Northern VA's contracts with various insurance companies, we must bill for services rendered within a timely manner (defined by the individual contracts). If it is found that the correct information was not provided by the parent for the services rendered and we miss the timely filing time limit, the patient will be responsible for the entire amount owed.
7. If uninsured, the parent/guardian is fully responsible for all fees. Uninsured patients will receive a 25% discount if the full balance is paid at the time of service. Payment is expected prior to being seen for all well-child care.
8. Payment is due at the time services are rendered. Co-payments not paid at the time of service will be billed an additional $35.00 fee. After the explanation of benefits from the insurance company is received, any balance that is determined to be patient responsibility is at that time. Well-child care will be deferred until all balances are paid in full. Accounts that are in collections will be discharged from the practice
9. There is a $50 processing fee for a credit or debit card that is declined for any reason. There is a $50.00 fee for all returned checks. Writing a "bad check" is punishable under law. If the account is not resolved fully within 7 days of notification from your bank that the funds were not available, we reserve the right to terminate any and all services provided to your family.
10. Fees for Forms (to include, but not limited to physical/sports forms, FMLA, forms for legal purposes): There will not be any charge for forms which are presented at the physical/well check appointment. However, forms requested outside of the physical/well appointment will have a minimum fee of $10. FMLA forms will be assessed a fee of $50.
11. Missed Appointment/Late Cancellation Policy – We understand there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Cancellations are requested 24 hours prior to well-care appointments and 2 hours prior for same day sick visits. PediatriCare of Northern VA, P.C. charges a fee for appointments that are missed or same day canceled; established sick patient $75, established well patient $125, new sick patient $150, new well patient $250. This fee is not covered by your insurance company.
12. If a patient arrives 15 minutes or more past their appointment time, your appointment may be rescheduled in order to keep the other patients and the doctors on time. This will be treated as a missed appointment and the applicable fee will be charged.
13. Should your child/children miss an appointment (No Show) and/or fail to cancel, we reserve the right to discharge you from the practice.
14. Any appointments that take place on a federal/observed federal holiday will incur an additional $60 fee that is billed to your insurance company.
15. When our office is closed or it is outside of normal business hours, there is a $35 fee for calls made to our after-hours on call service. This fee is not covered by your insurance company. After-hours calls are handled by the Rainbow Children's Hospital Call Center staff. They do not have access to your child's medical record. We encourage parents to call the office during regular hours, free of charge, for advice of a non-urgent nature, when our nurses have direct access to your child's medical record.

I understand by signing below that I have read, understand, and accept the policy listed above.

Patient's (Legal) Name	**Date of Birth**
1. ______________________________	____________
2. ______________________________	____________
3. ______________________________	____________
4. ______________________________	____________
5. ______________________________	____________

Signature ______________________________ **Date** ____________

Printed Name ______________________________ **Relationship** ____________