



# Advanced Pediatric Cardiology, PLLC

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### FINANCIAL POLICY

Thank you for choosing **Advanced Pediatric Cardiology, PLLC** for your cardiac care. We are committed to providing you with the best care possible. Our goal is to provide and maintain a good physician-patient relationship. This Financial Policy helps our practice to provide quality care for our valued patients. In order to reduce potential misunderstandings, our office has clarified our Financial Policy. We require that you read our Policy carefully and agree to comply with it prior to beginning or continuing treatment.

#### INSURANCE:

We must emphasize that as a medical care provider; our relationship is with you, our patient, not your insurance company. While the filling of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from **THE DATE SERVICE IS RENDERED**. If there is a change with the insurance information, you must inform us immediately. Failure to do so may result in you owing the entire bill. The services generated during your visit are always **YOUR RESPONSIBILITY** to make sure they are paid for. Payment is due for your outstanding balance as well as co-pay before your visit. According to your insurance plan, you are responsible for any and all co-payments, deductibles and co-insurances. We reserve the right to deny your visit if you do not have payment. **Please check with your insurance to make sure we are “in network” with your plan.**

#### PAYMENT:

- For patients with **private** or **no insurance**, full payment is required at the time of service.
- For patients with **HMO plans**, co-payment is required at the time of service. The amount of **co-payment** varies with different plans. You are responsible for knowing the co-payment amount.
- For patients with **PPO plan**, payment is required at the time of service until the new-year's deductible has been met. After that, we require co-payments or your liability to be paid at the time of service. •
- If you participate with a high-deductible health plan, we require a copy of the health savings account debit/credit card or a personal credit card to remain on file.
- For patients with **AHCCCS**: Please carefully read this review of our office policy on how we handle pending Medicaid applications:

\* We require that proof of application be presented to our office within 5 business days. Proof of application can be documented by official acknowledgment in writing from the Department of Social Services stating that your application has been received. If you have an upcoming appointment, we will need a copy of the letter noting your appointment date; we will then need the proof of application within the 5 working days from the date of appointment.

\* For accounting reasons, your medical charges will be listed as self-pay, but you will not be required to make payment on your account for the next 8 weeks. This is based on our understanding of the time it has been taking to receive a determination on your family's application. If the Department of Social Services indicates that it will need additional time, we will need that in writing.

\* If we have not received your Medicaid number for billing by 8 weeks or have not received an extension letter from the Department of Social Services, you will be required to set up a payment plan for services rendered. Extensions can only be given if you provide written proof of a continuing application.

\* It is your responsibility to request that Medicaid go back to the date of your application to cover outstanding medical bills that your family may have incurred. We strongly suggest that you make that clear at the time of application because we can only bill Medicaid for services on or after the effective date of your coverage, once approved. Any medical charges incurred prior to the effective date of coverage will remain your responsibility.

\* Our office cannot be responsible for speaking with social workers or for errors that may occur during your application process. This is a governmental process of benefit determination and approvals, between you and the Department of Social Services.

We are aware of how difficult and stressful this process can be for our families. Please contact our billing office if you have additional questions or concerns.

#### **NON-COVERED SERVICES:**

Please be aware that some – and perhaps all – of the services you receive may be uncovered or not considered reasonable or necessary by insurers. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. If your health plan determines that a service is “not covered” you will be responsible for the entire charge. This office is not responsible for disputing decisions made by your insurance carrier regarding coverage. You are due for payment of these services in full at the time of visit.

#### **PROOF OF INSURANCE:**

We must obtain a copy of your valid driver’s license/photo ID and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information before your visit, you may be responsible for the balance of a claim. It is the patient’s responsibility to provide us with current insurance information and to present an active insurance card at each visit.

#### **CLAIMS SUBMISSION:**

We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

#### **PAST DUE PAYMENTS:**

Just as we make every effort to accommodate you when you need medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety, please contact our billing office to discuss payment options. **We reserve the right to report delinquent balances to credit bureaus, assess a collection fee, and/or take other collection action.** Therefore, if your account is over 60 days past due, you will receive a statement stating that your balance will go to collections. Please be aware that if a balance remains unpaid, we will then refer your account to a collection agency unless other arrangements have been made. Any fees imposed in the collection of your account are the guarantor’s responsibility and may be recovered in a courtroom, along with any associated court and attorney’s fees. Accounts that are turned over to collections may result in dismissal from our practice.

#### **FORMS OF PAYMENTS:**

We accept Visa, MasterCard and Discover Cards, as well as cash and personal checks.  
**WE DO NOT ACCEPT AMERICAN EXPRESS.**

#### **UNINSURED/SELF PAY:**

We are happy to offer a discount to our patients who are uninsured. Payment is expected at the time of service if you are uninsured. If you find you need a payment plan, please feel free to discuss this with our staff, preferably before services are rendered to make the appropriate arrangement. **PLEASE BE ADVISED THAT A CREDIT CARD ON FILE WILL BE REQUIRED FOR ALL PAYMENT PLANS.**

#### **RETURNED CHECKS:**

A \$20 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

We thank you for understanding our policies. Our goal is to make your visit with us pleasant and professional.

For more information or to report a concern, you may contact our office directly at **480-855-1339** or email us at [staff@apcardio.com](mailto:staff@apcardio.com)

**Thank you again for choosing Advanced Pediatric Cardiology for your heart care.**