



PATIENT FINANCIAL POLICY

Child and Adolescent Health Associates, Ltd (CAHA), is committed to providing the highest quality health care for your child. As part of your relationship with CAHA, a clear understanding of our financial policies is important so you are aware of your financial responsibilities.

Your health insurance policy is a contract between you and the insurance company this requires us to ask you comply with the following items:

- Present your primary insurance card at the time of service.
- Present a picture ID (driver's license preferred) for verification of identity.
- Inform CAHA as soon as possible if your insurance carrier changes.

After Hours Telephone Calls

Each insurance company has their own policy related to reimbursement for After-Hour phone calls. Please contact your insurance company to understand what services are covered and what you may be financially responsible for. CAHA will bill according to insurance guidelines for calls to the on-call physician when the office is closed.

Physician / Nurse Practitioner Telephone Consultations

Telephone consultations may be offered for families who have questions which require significant provider time, such as behavioral and developmental issues, follow up for chronic illnesses, or special services such as those related to travel health. Fees for telephone consultations will be billed to your health insurance company according to the established insurance guidelines. Similar to After Hour calls, each insurance company has their own policy related to reimbursement of these services. Please contact your insurance company to understand what services are covered and what you may be financially responsible for. Please note, this charge does not apply to calls to our nursing staff during regular business hours.

Responsibility for Payment

CAHA will bill your primary insurance company for all services rendered, with the information you have provided us. If your insurance information has changed, please notify us immediately so we may bill the correct insurance carrier. Even though you have health insurance, you as the guarantor, are responsible for payment of all services provided by CAHA.

Co-Payment

Your health insurance policy may require a co-payment for physician visits. This payment is due at the time services are rendered. CAHA accepts Checks, Visa, MasterCard, American Express, and Discover.

Remaining Balance After Your Insurance Company has Paid

CAHA will submit a claim to your primary health insurance company for services provided. Once your primary and secondary insurance company has processed your claim, CAHA will post any payment it receives to your account. If there is a remaining balance, the balance is now your responsibility. This balance may include your deductible, coinsurance and all non-covered charges. This charge will be assessed monthly until the balance on the account has been satisfied.

Divorced Parents

CAHA will not get involved in custodial, separation or financial disputes involving or relating to divorced parents for a minor child. The parent who signs the financial policy and registration form for the minor child/children will be the responsible party for payments of services rendered. Please refer to CAHA's Policy Regarding Divorce, Separation and Custody Agreements for further details.



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Failure to Pay Outstanding Balance

Our office will make every effort to communicate with you about your account and will present reasonable options for payment. In the event a bill goes unpaid, without contacting our Billing Dept. to discuss payment options, the account will be turned over to collections. If your account is sent to a collection service a charge of 1.5%, of the amount due, will be added to the balance on your account.

Additional Fees

Request for Medical Records	\$0.50 / page
Checks returned to CAHA for "non-sufficient funds"	\$25.00
Saturday office visits	\$25.00
No-show (scheduled visits which are not cancelled and/or rescheduled 24 hours in advance)	\$65.00

I certify that my child is covered by the insurance provided and assign directly to CAHA all Insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Summary of our Notice of Privacy Practices

We understand that patient information about you is personal and are committed to protecting the confidentiality of your patient information. When required by law, we will obtain your authorization before using or disclosing any of your patient information

You have the following rights regarding patient information we maintain about you:

- Right to inspect and copy patient information in your medical or billing records
- Right to request an amendment of patient information in your medical or billing records
- Right to an accounting of certain disclosures made by us
- Right to communicate with us via alternative means or have communications sent to alternative locations
- Right to request restrictions on how we use or disclose your patient information
- Right to revoke an authorization given to us

Although you have these rights, we may deny your requests if they do not meet certain requirements.

If you have any questions about this Notice, your privacy rights described above or believe your privacy rights have been violated, please contact CAHA.

I have read the above financial policy and summary of Privacy Notice for CAHA and I agree to the terms listed above.

Print Name _____ **Signature:** _____ **Date:** _____
 Parent or Legal Guardian

1. Child:	Date of Birth:
2. Child:	Date of Birth:
3. Child:	Date of Birth:
4. Child:	Date of Birth:



CHILD AND ADOLESCENT HEALTH ASSOCIATES, LTD

1030 N. CLARK STREET, 4th Floor, CHICAGO IL 60610 PHONE: 312.943.6964, FAX: 312.943.6924

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5. Child:	Date of Birth:
6. Child:	Date of Birth: