

# Ball Pediatrics

3619 Braselton Hwy, Suite 103  
Dacula, GA 30019  
Phone: (770) 513-8882  
Fax: (770) 513-3545

2610 Highway 129 N  
Jefferson, GA 30549  
Phone:  
Fax:

## Financial Policy

**Insurance:** As a courtesy, we file claims with participating insurances on your behalf. It is your responsibility to keep us up to date with your current and active insurance policy. While we make a good faith effort to assist you in maintaining your benefits, it is your responsibility to make sure we are in network with your plan and that you read your insurance policy and be fully aware of any limitations of the benefits provided. You are expected to pay your deductible/copayment at time of service. If we have not received payment from your insurance company within 90 days from the date of service, the amount will become due and payable by you. If you do not provide us with up to date insurance prior to/at time of service, you will be held responsible for any outstanding debt not paid for by the insurance company.

**Copayments/deductibles:** Depending on your insurance policy, a copay/deductible or coinsurance may be required at time of service. Payment can be made in cash, check, or credit card. We also accept Health Savings Account cards (HSA) for payment. Please note that the copayment is a contractual requirement by the insurance company and cannot be written off by the clinic. Coinsurance may apply even after meeting your deductible. Please note that there is a \$25.00 service charge for any returned checks.

**Patients without insurance coverage/non-covered charges:** We are happy to work with patients who do not have insurance or who prefer to pay directly for services. All self-pay payments are due at time of service. Please contact the office for information on self pay pricing.

**Balances:** Patients with an outstanding balance over 60 days must make at least a partial payment or payment arrangement prior to scheduling any further appointments. There will be a hold on your account until arrangements are made. Accounts with large outstanding balances are subject to dismissal from practice and risk the account being sent to collections.

**Missed appointments/Late cancellations:** Missed appointments cause a delay in care to other patients. Any cancellation or late show without at least a 2 hour notice will be subject to a \$30.00 fee for each appointment. We respectfully ask all patients to arrive 15 minutes early for well checks and 10 minutes early for sick visits. We understand people run late due to circumstances beyond their control. If you are running late we ask that you call and notify the office. After three no-shows your family is subject to dismissal from practice. We reserve the right to dismiss any new patients who no-show/no-call for their initial visit.

**Patient/Parent/Guardian Responsibility:** I understand that whomever accompanies my child to their appointment has my consent for medical care and is responsible for payment of medical services at time of service. In the case where parenting/custody plan is in place, the parent that brings the child in for care is considered the guarantor and is responsible for payment.

**Medical Record Requests:** Please note that Ball Pediatrics does not charge for Basic Medical Records that are faxed or emailed. Complete Medical Records can be emailed for no additional fee. Complete medical records are often too large to fax; therefore they cannot be faxed. For the printing of medical records, there is a \$20 fee that is due at time of pick up.

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## **Consent to Use and Disclosure of Protected Health Information:**

I hereby give consent for Samantha Ball, DO, LLC doing business as Ball Pediatrics, to use and disclose protected health information (PHI) about me/the patient to carry out treatment, payment, and healthcare operations (TPO).

With this consent, Samantha Ball, DO, LLC doing business as Ball Pediatrics may mail to my home or alternative location as well as email or text any items that assist the practice in carrying out TPO, such as appointment reminders, lab results, and patient statements marked personal/confidential.

I have the right to request that Samantha Ball DO, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

**Assignment and Release:** I authorize payment to be made directly to Ball Pediatrics 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.