Financial and Office Policy

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Vaccination/Well Check Policy

At White Cloud Pediatrics, we follow CDC guidelines and strongly recommend vaccinating children on schedule to protect their health and others. Please provide proof of vaccination before the first visit if received elsewhere. Families choosing not to vaccinate may need to seek care elsewhere, as our priority is your child's well-being.

Additionally, well visit check ups are crucial for monitoring growth and health. Starting 01/01/2025, patients must be up to date on these visits to keep scheduling sick appointments.

Insurance Participation and Financial Agreement: Fees, Insurance, and Health Plans

White Cloud Pediatrics accepts **most** insurance plans. Please verify your coverage and payment responsibilities with your insurer before your visit. Parents/guardians **must update** contact and insurance information. Payment is due at the time of service. If benefits cannot be verified, full payment is required or appointment will need to be rescheduled. Co-pays, deductibles, and any uncovered services are the patient's responsibility. For coverage or billing questions, please contact your insurer.

Patients Without Insurance Coverage and Newborn Coverage

We offer a time-of-service discount for uninsured patients if the bill is paid in full on the day of service. This discount is not available after the visit. **You must bring all payments with you on the day of your appointment or you will be asked to reschedule.**

Most insurances cover the baby under the mother's policy for 30 days, but this can vary. White Cloud Pediatrics provides a 60-day grace period to add the baby. If not added by the 2-month well visit, the visit may need to be rescheduled or self pay. Self pay for both the well visit and vaccines means claims **can't** be submitted, but if only the well visit is self pay, vaccines can be administered later with claims submitted for reimbursement. Please ensure the baby is added within 60 days to avoid billing issues.

Copayments and Deductibles Policy

Depending on your insurance policy, a copayment and/or deductible may be required at the time of service. These payments are expected to be made at the time of your visit. If you need assistance with payment, we are happy to discuss payment arrangements by installment. We accept payments via Cash, Check, Card, and Health Savings Account (HSA) cards.

- Copayment: This is a contractual requirement from your insurance company and cannot be waived or written off by the clinic.
- High Deductible Health Plans (HDHPs): If you are enrolled in an HDHP and have not yet paid your deductible in full, it is likely that non-preventive services will require payment at the time of service.

Outstanding Balances Policy

Outstanding balances are due upon receipt. Payment is required at visits for overdue accounts; otherwise, appointments may be rescheduled. Accounts over 120+ days past due may incur fees, interest, and/or pursue internal collection efforts. Emergency care will be provided for 30 days, but future appointments require balance resolution. Payment plans are available with a credit card on file to ensure continued care. If you are unable to pay, a payment agreement must be made, and a credit card put on file. We will work with you, but timely payment is necessary to continue care.

Auto Pay Policy/Credit Card On File

White Cloud Pediatrics has implemented an **Auto Pay System** to streamline the billing process and ensure timely payment of patient balances. This system is designed to simplify billing while maintaining transparency and flexibility for families. **Key details include:**

- A **credit card is required on file** for all patients to facilitate payments for copays, coinsurance, deductibles, or balances at the time of service.
- Once insurance claims are processed, any outstanding patient responsibility will be charged to the card on file.
- **Notification and approval** will be provided to the parent/guardian prior to processing any charges.
- Families who prefer not to use Auto Pay may opt out but must ensure that payments are made promptly to avoid additional fees.
- It is the parent/guardian's **responsibility to keep payment methods updated**, such as replacing expired cards, to avoid declined payments or associated fees.

Financial Responsibility in Custodial or Divorced Situations

White Cloud Pediatrics does not get involved in disputes between divorced or separated parents regarding financial responsibility. By signing as the guarantor, you agree to be financially responsible for your child's care, regardless of any divorce or custodial arrangement. We can provide receipts for paid bills upon request.

Annual Administrative Fee (AAF)

White Cloud Pediatrics assists with school, daycare, camp, sports forms, medical letters, and non-medical insurance forms (e.g., FMLA, disability). We also provide access to secure messaging via Spruce and My Kid's Chart.

To support essential services like nurse triage, insurance authorizations, messaging, and prescription coordination, we charge an annual fee of $25 per patient or $75 per family, which is not covered by insurance.

Processing Times:

- Prescription Refills: Require 72 hours' advance notice
- Referrals & Forms: Require 3-5 business days for processing

Appointments/Cancellation/Late Office Policies

At White Cloud Pediatrics, we value your time and ask that you respect ours. While we offer same-day appointments, all visits must be scheduled in advance—no walk-ins. If you need to cancel or reschedule, please notify us as soon as possible. If you are unable to attend, please cancel by 3 pm the day before. Failure to do so or not showing up will be considered a "no-show." Repeated no-shows may result in transferring your care to another provider.

- **Late Arrivals**: A 15-minute grace period is allowed. Appointments after this time may be rescheduled.
- **Appointment Cancellations and No-Shows**:
    - Advance notice of 24-48 hours is required for cancellations or rescheduling.
    - Fees for missed appointments range from $50 to $100.
    - More than three missed appointments may result in being asked to transfer care.

□ I have read and understand the No-Show Policy and acknowledge that I will be held accountable as specified above.

I have read and understood the above policy and agree with it.

Guarantor / Responsible Party's Signature: _____ Date: _____

Guarantor / Responsible Party's Name: _____

****Some of this policy does not pertain to Medicaid patients****