Pediatrics East Of New York Financial Policies

Thank you for choosing Pediatrics East Of New York, P.C. for your medical care. We appreciate that you have entrusted us with your health care needs as we pride ourselves in providing the best pediatric care to your family.

The current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured. Some insurance plans require deductibles and copayments in amounts not known to you or to us at the time of your visit. Please be advised that you are responsible for knowing your insurance plans rules and regulations. This may include but not be limited to the need for referrals, pre-certifications, pre-authorizations or limits on outpatient charges and visits. We encourage you to be knowledgeable of any deductibles, copayments, and/or other possible requirements by your insurance plan.

Insurance Coverage: We will request a copy of your insurance card to copy or scan and keep on file for our records. We ask that you notify us of any changes to your insurance coverage prior to each visit in order to ensure proper billing. Failure to provide this information in a timely fashion may lead to lack of payment from your insurance plan. In this case you will be responsible for these unpaid charges.

We follow AAP recommendations and book well child visits according to those guidelines. As each insurance plan has its own guidelines; please note that it is your responsibility to verify with your insurance plan that these recommended visits are covered.

Co-payments/Co-insurances/Deductibles: We are legally obligated to collect from you co-payments, deductibles and co-insurance amounts. These amounts are determined by your health insurance plan. Coverage for services provided by our physicians varies from plan to plan. If our physicians provide your children with services, which are not be covered by your insurance carrier, you will be responsible for their payment. In order to provide the highest quality comprehensive medical service every child deserves; we follow AAP clinical guidelines. However, insurance companies may not keep up with clinical guidelines. Coverages for basic screening tests (i.e. vision or hearing tests) could change on an annual basis. When these changes are implemented, your insurance carrier will typically notify you and thus it's your responsibility to let us, your child's medical provider, know about these changes in coverage.

Payments: All payments, including co-insurance and/or deductible amounts are due on the dateof service. All co-payments are due at the time of registration. Please be aware that you are financially responsible to pay any and all remaining balances for the medical services provided until your deductible is met. Payment is due at the time services are provided or upon receipt of a statement from our billing office. We accept payment in the form of cash, check, money order or credit card (MasterCard, Visa).

Out of Network Services: Please be advised that if we do not participate in your health insurance plan full payment is due at the time of visit. An invoice of the visit will be provided to you so you may submit to your insurance for any available out of network reimbursement. Please note that charges may be incurred for services which do not involve direct physician contact, these may include venipuncture for follow up labs,diagnostic testing and other services Extended telephone based patient care and consultations will incur a fee which is not covered by most insurances.

Newborn Care: Please add your newborn to your insurance policy AS SOON AS POSSIBLE, preferably within 14 to 21 days from birth. Your insurance will be billed for newborn hospital visits & and office exams. If the newborn is not added onto the policy in a timely manner, some insurance carriers

will permanently deny payment for your newborn's in-hospital care and first month visit to the office. If this occurs, you will be personally responsible for the payment of those services received.

Credit card on file: We require a valid, current Visa/ Mastercard on file for all patients. This card may be charged for various reasons including: payments not collected from you at the beginning of your visit (copayments and deductibles), diagnostic test balances, patient responsibilities as indicated from EOBs , no show or late cancellation fees , insurance discrepancies that are not resolved within 90 days of the date of service, outstanding balances greater than 90 days past due, and payment plans. Billing your credit card will not compromise your ability to dispute a charge or question your insurance company's determination of payment.

Failure to Pay: There is a $25 administrative fee if co-payments are not paid at the time of service.

Outstanding balances that remain unpaid for more than 30 days will incur a $10 recurring billing fee as there is expense involved in sending out monthly statements. If you are not able to make the full payment at once, we are willing to work out a monthly payment plan which involves you paying at least 25% of the outstanding balance each month automatically and in doing so we will waive the $10 recurring billing fee. A declined payment is a cancellation of said agreement and $10 fee will be incurred. If there is no payment or payment plan set up for your outstanding balance for 60 days, your account will be suspended and sent to collection agencies. We will not be able to provide any preventative medical services until payment on said account has been re-established.

Administrative & Non-Medical/ Fees Additional: The following fees apply to these listed services: :

Camp/ School/ Other Forms: $20 per form (Additional $10 expedited fee per form)

Ear piercings: $200

No show/ NO call Missed appt fee $75 per patient

Returned checks fee: $50.00

Copying of medical records $0.75 Cents per page

Letters: $50

We are aware that medical care can become expensive. If you have concerns about your ability to pay, you can contact us for help in managing your account. If you have questions about these policies, feel free to contact our biller for further information at the number listed on you statement. We will do our best to keep you informed of any modifications.

By signing this statement, you:

Agree to pay all charges due or that become due to Pediatrics East of New York for services, care and treatment,

Acknowledge and accept full financial responsibility for **ALL** medical services provided.

Acknowledge receipt of this financial policy.

_____ _____

Patient/Representative Signature Date

If the patient listed above is a minor or is unable to sign, and you are a parent, legal guardian, or personal representative who will use e-mail to communicate about this patient, please sign above and complete the following:

_____ _____

Print name Relationship to patient Date