Financial Policy

Patients Name: _____ Date of Birth: _____

We welcome you to our practice. The following is a statement of our financial policy. All patients must complete our Patient Information Sheets before seeing the doctor.

Unless previous arrangements have been made, all payments are due at the time of the appointment. Payment will be accepted by cash ONLY. We will only bill insurance carriers with whom we participate (have signed an agreement with).

Regarding Managed Care Insurance with which we participate: You are responsible to supply our staff with your primary and secondary insurance identification card(s) **at the time of your appointment**. If your insurance requires co-pay or deductible, **it must be paid at the time of the appointment.**

At times your insurance carrier will deny payment for authorized services. If so, you may be asked to help resolve these issues with your carrier.

Regarding Non-Participating Insurances: If we do not participate with your insurance, the bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not part of that contract.

Our practice is committed to providing the highest quality of treatment to our patients, and we charge what is usual and customary for our area. We know how confusing insurance plans can be. If you have any questions, feel free to ask us. We may be able to help you.

Returned Check Fee - $35.00. Our bank charges us a fee for any check that is returned for 'insufficient funds" and this will be added to the patient's bill if this occurs.

If you are unable to keep a scheduled appointment, 24 hours notice of cancellation is required. Otherwise a $35.00 charge will be made for the time that was reserved to you.

Any outstanding balance for which the patient is responsible is due within 14 days of billing. Any account that has gone 14 days without payment is subject to immediate collection process. Accounts that go to out side agency/ attorney for collection will be subject to 35% additional charge plus attorney's fees. After one year additional charge will be 45 % plus attorney's fees

Thank you for your cooperation in understanding our financial policy. If you have any question or concerns, please feel free to ask. If you cannot pay in full at the time of service, please let us know before you see the doctor that you would like to discuss a payment plan.

I have read the above Central Jersey Pediatrics Financial Policy. I understand and agree to abide by its terms.

_____ _____ _____
Signature of Patient/Parent/Guardian Print Name Date