University Pediatric Associates Financial Policy 2017

Welcome and thank you for choosing our practice for your medical care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill. As a courtesy to our patients, we accept cash, personal check, money order, and 4 credit cards.
In order to achieve our goal of providing you with the best care possible, we need your assistance and understanding of our financial policy:

Things to bring with you to EACH appointment:

1. Health Insurance Card (s)
2. Method of Payment

Copays:

Copays are due at the time service is rendered. The person presenting the child for the visit is responsible to make the copay.
A billing charge of $5 will be added if the copay is not made at the time of the visit. This billing charge will be waived if paid within 7 days of that visit.

Appointments:

1. Please make a note on your calendar. We try to place a courtesy reminder call for certain appointments, but it is not always possible.
2. It is your responsibility to verify the physician is currently under contract with your insurance plan. If it is necessary to have a PCP (primary care physician) selected on your plan, you should to that BEFORE the scheduled appointment. (Failure to do this may result in additional charges, that are your responsibility). You may contact our billing department if you are unsure of any of the above BEFORE the visit and they will try to assist.
3. Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc). Failure to notify us immediately of changes in demographic information, financial status, and/or insurance coverage may result in you being responsible for services not covered by your insurance carrier.
4. 24 hours notice is required to cancel/reschedule all appointments. Please be courteous of other patients who may need that appointment. Failure to do so will result in a $25 No Show Fee.
5. Visits are available on Sundays and Holidays from 10am to 12 noon. There is an additional charge of $20, which will be included in the claim sent to insurance. This charge applies to patients with insurance coverage and also to self-pay patients.

Payment in full is due at the time service is rendered:

1. If you receive more than one type of service on the same day, you may be responsible for more than one co-pay. This is determined by your insurance company when they process the claim.
2. Any amount not covered by the insured/patient's insurance is due within 30 days of the first billing sent by us.
3. Failure to pay balances may result in discharge from the practice.
4. Patient accounts that have to be sent to a collection agency will be discharged from our practice.
5. There will be a $35 fee for any returned checks to our office.
6. You may sign our Patient Pay Easy Consent form in order to keep a credit card on file (the same process you would go through for hotels, rental cars, etc.) to be used for any unpaid balances, or copays. Just ask the receptionist for the form.

Additional Paperwork:

Any paperwork needed to be filled out by the physician will result in either a $5 or $10 charge to be paid upon submission. A recent routine exam/or other exam may be necessary in order for certain forms to be completed and we will advise you of that. Please allow up to two weeks for completion.

"In Network" vs "Out of Network" Insurance:

1. Your insurance coverage and benefits are a contract between you and your insurance and therefore all disputes must be handled between you and your insurance company. We bill you what they determine is your responsibility. If you feel you have received a bill from us in error, please call the insurance company with the date of service and ask them for clarification.
2. We are contracted with multiple insurers to accept assignment of benefits, and all plans are different, even with the same insurer. You are responsible to know what your insurance will or will not cover. This applies to all lab work and radiology tests we may order done. Our doctors provide and suggest services that we feel provides the child with the best quality of care, not by what the insurance companies do or don't pay. Please KNOW YOUR PLAN.
3. If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a self patient, and payment is due that day for services rendered. Any state-funded (SCHIP/Medicaid) plans, we do not participate with at this time, and we are not allowed to treat you as a self pay.

Minor Patients:

1. The parent (s) or guardian (s) accompanying a minor is responsible for providing current insurance information for the minor as well as the copay, or payment in full for services provided. An Authorization for Medical Treatment form must be signed each time a minor arrives unaccompanied for an appointment, or ask the receptionist for a form to keep in the child's chart giving authorization for the same person to bring the child.
2. In compliance with HIPPA regulations, we are unable to discuss any details of the services rendered or to produce and itemized bill for any parties that are not the patient, unless otherwise documented.
3. In situations where parents of minors are divorced, payment arrangements are between the parents- not between us and the parents. Both parents will be sent a billing statement if we are provided with the address.

Payment Plans:

If a situation arises where you can not make the full payment due within 30 days of receiving our bill, we may be able to assist you with payment, through utilizing a payment plan. Our office will discuss a payment plan with you, but we need to be contacted as soon as possible following the first bill sent. Our billing department's phone number is 732-846-4966. (TURN PAGE OVER)

Patient Consent Form

By signing this document, I have fully read and understand the financial policy of University Pediatric Associates. I hereby consent to allow the practice to reach me via: (check all that apply):

__Home phone: (____)_____ - _____
__Cell phone: (____)_____ - _____
__Work phone: (____)_____ - _____(circle mom or dad)
__Email: _____(circle mom or dad)

I will cooperate with the billing department of University Pediatric Associates to ensure payment for services rendered to child(ren), and understand the terms of this financial policy. I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. In the event that the patient is a minor, I am the parent and/or legal guardian of said parent and agree that I am responsible for payment for all services rendered to the patient herein.

_____
Printed Name of Parent/Guardian

_____ _____/_____/_____
Signature of Parent/Guardian Date Signed

Please return signed document to front desk receptionist.
A copy is available for you at your request.

Revised 05/23/17

UNIVERSITY PEDIATRIC ASSOCIATES, P.A.

ELLIOT RUBIN, M.D.
MEDHA GAVAI, M.D.
DOUGLAS EDELMAN, M.D.
SHERYL JOHN, M.D.
ROCHELLE HENNER, M.D.
JODI ZALEWITZ, M.D.
MYRIAM HERNANDEZ, CPNP

INFANTS,CHILDREN AND ADOLESCENTS

317 Cleveland Ave
Highland Park, NJ 08904
Phone: 732-249-8999
Fax: 732-249-7827

D-1 Brier Hill Court
East Brunswick, NJ 08816
Phone: 732-238-3310
Fax: 732-613-6051

AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE:

_____

Doctor or Hospital

TO RELEASE MEDICAL RECORDS ON:

Name_____Date of Birth_____

_____

_____

_____

PLEASE FAX/MAIL TO:

UNIVERSITY PEDIATRIC ASSOCIATES, P.A.
D-1 BRIER HILL COURT
EAST BRUNSWICK, NJ 08816
FAX : 732-613-6051

SIGNATURE_____DATE:_____

Parent/Guardian or Patient if 18 Years Old

Revision 05/23/17

University Pediatric Associates, P.A.

PATIENT & FAMILY INFORMATION UPDATE FOR THE YEAR OF: **2017**

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Patient's Last Name:________________**First:**____________**Middle Initial:**____

Address:________________**City, State, Zip:**________________

Home Phone #: (____)____-_____**Cell Phone:** (____)____-_____

Patient's DOB: ___/___/____ Sex: Male / Female / Other: ______ (Circle) – Is Patient A College Student? Yes / No

Father's Employer:________________**Job Title:**____________

Phone #: (____)____-_____ **EXT:**______ **E-mail:** ____________

Mother's Employer:________________**Job Title:**____________

Phone #: (____)____-_____ **EXT:**______ **E-mail:**____________

Who Carries **PRIMARY** Insurance on the Patient(s)? Circle One of the Following:

Mother Father Patient Other (Explain):____________

PRIMARY Insurance Company Name:________________

Insurance Co. Address:________________

ID#____________Group #:____________**Policy Effective Date:** ___/___/____

Who Carries **SECONDARY** Insurance on the Patient(s)? Circle One of the Following:

Mother Father Patient Other (Explain):____________

SECONDARY Insurance Company Name:________________

Insurance Co. Address:________________

ID#____________Group #:____________**Policy Effective Date:**___/___/____

** If you have any changes of coverage throughout the year, please notify us immediately **
Changes may affect where any lab work or tests are done. You are responsible for knowing the terms of your contract with your insurance company. If your insurance has a co-pay, please make payment upon arrival.

In order to produce a proper insurance claim for any visit, the following **MUST** be filled out.

Mother ☐ Father☐ Other ☐ : ________________ **DOB:** ___/___/____SSN #:___-___-___

Address: :________________City, State, Zip:________________

Mother ☐ Father ☐ Other ☐ : ________________ **DOB:** ___/___/____SSN #:___-___-___

Address: :________________City, State, Zip:________________

Which Doctor did you chose for your child's **Primary Care Physician?** ________________

Pharmacy Name:____________City:____________Phone #: (____)____-_____

List **ANY** other children that may also come to the practice:	(Circle)	College Student?
First Name:__________MI:_____DOB: ___/___/____	Male / Female	Y / N
First Name:__________MI:_____DOB: ___/___/____	Male / Female	Y / N
First Name:__________MI:_____DOB: ___/___/____	Male / Female	Y / N
First Name:__________MI:_____DOB: ___/___/____	Male / Female	Y / N
First Name:__________MI:_____DOB: ___/___/____	Male / Female	Y / N

I have read & verified that the above information is correct & no changes need to be made.

X:____________________**Today's Date:** ___/___/____

University Pediatric Associates – Well Child Immunization Schedule

Birth/Newborn Check-up	Hepatitis B #1
1 Month Well Visit	Hepatitis B #2
2 Month Well Visit	Pentacel* #1 (OR DTap, IPV & Hib) Prevnar #1 (Pneumococcal) Rotateq #1 (Rotavirus, Oral vaccination)
3 Month Well Visit	(Catch-up vaccines if needed)
4 Month Well Visit	Pentacel #2 (OR DTap, IPV & Hib) Prevnar #2 Rotateq #2
6 Month Well Visit	Pentacel #3 (OR DTap, IPV & Hib) Prevnar #3 Rotateq #3 Flu Vaccine (Flu booster required @ 7 months, annually thereafter)
9 Month Well Visit	Hepatitis B #3
12 Month (1 Year) Well Visit	Prevnar #4 MMR #1 (Measles/Mumps/Rubella)
15 Month Well Visit	Varivax #1 (Varicella or Chicken Pox) Hib #4 (Haemophilus Influenzae Type B)
18 Month Well Visit	DTap #4 (Diphtheria/Tetanus/Pertussis) Hepatitis A #1
24 Month Well Visit	Hepatitis A #2
30 Month Well Visit	(Catch-up vaccines if needed)
3 Year Well Visit	Annual Flu Vaccine
4 Year Well Visit	DTap #5 IPV #4 (Polio) MMR #2 Varivax #2 Annual Flu Vaccine
5-10 Year Well Visit	Annual Flu Vaccine
11 Year Well Visit	TDap (Tetanus/Diphtheria/Pertussis) Menactra #1 (Meningococcal) Gardasil (HPV Vaccine, 2 Shot Series**) Annual Flu Vaccine
12-15 Year Well Visit	Annual Flu Vaccine
16 Year Well Visit	Menactra #2 Flu Vaccine
17-22 Year Well Visit	Annual Flu Vaccine Trumenba (MenB, 3 Shot Series)(if indicated)

**Pentacel is a combination vaccine. It's components include DTap, IPV & Hib.*
***Gardasil is a 2 dose series only if started prior to 15th birthday*