University Pediatric Associates Financial Policy

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 orders and all major 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 accompanying the child for the visit is responsible to make the copay.

Appointments:

1. Please make a note of your appointment 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 that University Pediatric Associates/specific doctor is currently under contract with your insurance plan, If your insurance requires you to select a PCP you should do this before your 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 (Ex: 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 plan.
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. Sick visits are available on Sundays and Holidays from 10-12 pm. There is an additional charge of $20, which will be included on the claim sent to insurance. The charge applies to patients with insurance coverage and also to self-pay patients.

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

1. If you receive more than one type of service on the same day, you may responsible for more then one co-pay. This is determined by your insurance company when they process the claim.
2. Any amount not covered by the insured/patients insurance is due within 30 days of the first billing sent by our office.
3. Failure to pay balances may result in discharge from the practice.
4. Patient whose accounts have been sent to a collection agency will be discharged from our practice.
5. There will be a $35 fee for any returned checks.

Additional Paperwork:

Forms needed to be filled out by the physician will result in either $5 or $10 charge to be paid when the form is submitted to the office for completion. An updated well visit or comprehensive visit will necessary in order for certain forms to be completed. Please allow up to two weeks for completion. (Please talk to the front desk for any further details.)

"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 will bill you what they have determined is your responsibility. If you feel you have received a bill from us in error please call the insurance company with the day of service and ask them for clarification.
2. We are contracted with many insurers; specific plans can be 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. 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 ro do not pay. Please KNOW YOUR INSURANCE PLAN.

Minor Patients:

1. The parents (s) or guardian (s) accompanying a minor are responsible for providing current insurance information for the minor as well as the copay, or payment in full for services provided.
2. In compliance with HIPPA regulations, we are unable to discuss any details of the services rendered or to produce an itemized bill for any parties that are not the patient, unless otherwise documented.
3. In situations where parents of a minor 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 addresses.

Payment Plans:
If a situation arises where you can not make the full payment 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.**

University Pediatric Associates
Patient Financial Consent Form

By signing this document, I have fully read and understood the financial policy of University Pediatric Associates. I hereby consent to allow the practice to reach me via:

□ **Home Phone Number (____) _____-_____**

□ **Cell Phone Number (____) _____ -_____**

(Name) _____
Please Print

□ **Work Phone Number (____) _____ -_____**

(Name) _____
Please Print

I will cooperate wit 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/pr legal guardian of said patent and agree that I am responsible for payment for all services rendered to the patient herein.

X_____
Signature of Parent/Guardian

_____ **_____/_____/_____**
Printed Name of Parent/Guardian **Date signed**

Revised September 11, 2018