ADULT & PEDIATRIC ALLERGIST OF CENTRAL JERSEY P.A.

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Financial Policy

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

Unless previous arrangements have been made, all payments are due at the time of service. Payment may be made by cash, check, MasterCard, Visa or Discover. We will only bill insurance carriers with whom we participate.

Regarding Manage 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 company requires a referral from your primary doctor, you must also present this to our receptionist prior to begin seen, as we cannot bill your insurance without it. If you do not obtain a referral when your insurance requires one, you will be required to pay for the service in full. If your insurance requires a co pay, 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 one of our physicians do not participate, the bill is your responsibility. We accept cash, check, MasterCard, Visa and Discover. Your insurance policy is a contract between you and your insurance company.

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.

Medicare: We do participate with Medicare. This means that we will submit your claims to Medicare. The 20% difference between what Medicare "allows" and what Medicare "pays" will be sent to your secondary insurance if you have one, or to you. You will also be responsible for payment of your yearly deductible.

Return Checks Fee: $10.00. Our bank charges us a fee for any return check that is returned for "insufficient funds" and this will be added to the patient's bill if this occurs and their after payment must be made by cash, MasterCard, Visa or Discover.

Any outstanding balance for which the patient is responsible is due within 30 days of billing. Any account that has gone 60 days without payment is subject to immediate collection process. **Accounts that go to collection will be subject to a 25% charge.**

Thank you for your cooperation in understanding our financial policy. If you have any questions or concerns, please feel free to ask. If you cannot pay in full at 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 Adult & Pediatric Allergist of Central Jersey, PA Financial policy. I understand and agree to abide by its terms.

_____ _____
Signature of Patient/Parent/ Guardian Date