# Pediatric Eye Associates of Northern New Jersey

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## Financial Policy

Our office has direct financial relationships with many insurance companies. We will be happy to submit claims to these companies if you provide us with the necessary information and fulfill their requirements for referrals, etc. If your insurance company requires a referral, you should obtain it prior to your appointment, since a referral is necessary for all visits to this office.

We will be happy to help you with the details of your plans to the best of our abilities. However, with the myriad of different companies, we are not aware of all the details of all the plans. It is your responsibility to know what your plan requires. Therefore, you are responsible for all co-insurance, deductibles, and co-payments determined by your insurance. Not all services are covered by all insurance plans. If the claim for your visit is denied (due to not giving us a referral, etc.), by your insurance company, **you agree to be responsible for the full payment of your appointment.**

For many insurance plans, routine care, the prescribing of eyeglasses, and sometimes even medically-related eye problems such as "lazy eye" are not covered services. This is regardless of you being referred by another physician and may even be the case in the presence of a "referral". **Any denied claims or account balances will be your responsibility.**

You agree to timely payments of all charges. **If an account is delinquent over 60 days and must be referred to collections, a 25% fee will be added to the charges. A $30 fee will be added to the account for all checks returned for insufficient funds.**

**All co-payments must be paid at the time of your visit.** If you do not have your copay, we may not be able to see you. **If we do, you agree to mail your copay to be received within one week, or you understand that a $25 billing surcharge will be added to your copay amount.**
**If you miss your appointment or fail to notify us of your cancellation two business days prior to your appointment, you understand that there will be a $25 fee per child.**

If we do not have a relationship with your health insurance company or you are self-pay, you are responsible for the payment of services at the time these services are rendered. We will provide you a summary of charges to submit to your insurance company after the payment has been received.

It is understood that providing us with an invalid insurance card is tantamount to **INSURANCE FRAUD** and is a crime. You agree to provide accurate and up-to-date information concerning your health plan. You, also, agree to provide prompt notification of any changes in your insurance plan coverage (such as changes in copays, policy numbers, or insurance plans). As a preventable measure, the office does require the SSN of the insurance policy holder for all new patients. If you do not provide the most current insurance information at the time of your visit and the visit goes unpaid, you will be responsible for all the charges for that visit.

___ *I have read this information, as well as understand and agree with my financial obligations.*

Signature: _____ Date: _____

Patient's Name: _____

If you have any questions regarding our financial policy, please don't hesitate to ask our office @ 201-342-5544.
We will be happy to speak to you.