Pediatric Eye Associates of Northern New Jersey

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Financial Policy

Our office has direct financial relationships with many commercial 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. 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.**

Credit Card Policy: We request that every patient with a high-deductible plan to store a credit card on file. Your credit card information will be stored securely. We will submit a claim for every office visit and await payment from your insurance company. If a portion of the bill applies to the patient's responsibility, your credit card will be used to secure that portion. The Explanation of Benefits (EOB) will be provided by your insurance company, and it will provide all necessary details. Charges that do not successfully process or are denied through your credit card will remain your financial responsibility. If you choose not to leave your credit card on file, you must pay your estimated costs at the time of service.

You agree to timely payments of all charges. **Any balances that have not been paid within 60 days of the explanation of benefit, will incur an additional late charge fee of 25%. Any account that has not been paid 90 days from the explanation of benefits will be sent to collections. We will not be able to reverse any accounts that have been sent to collections. A $30 fee will be added to the account for all checks that bounce and/or are returned for insufficient funds.**

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 ($35 for any new patient).
All co-payments must be paid at the time of your visit. We may not see you if copay is not provided at the time of your visit.

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.

We are committed to providing you with the highest quality of health care and are happy to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility. 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 and benefit plans, we are not aware of all the details of your insurance plan. It is your responsibility to know what your plan requires. Therefore, you are responsible for all co-insurances, deductibles, and co-payments determined by your insurance. If the claim for your visit is denied (due to not giving us a referral, coordination of benefits, etc.), by your insurance company, **you agree to be responsible for the full payment of your appointment.**

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

Signature:_____Date:_____

Patient's Name: _____