J&R Pediatrics

Payment Policy

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable health care. Please read our payment / financial policy, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1.Insurance. We participate in most commercial insurance plans in New Jersey which we will contact to verify eligibility and benefits. Please realize that **you have the ultimate responsibility of verifying the coverage with your insurance.** If you are not insured by a plan we are in-network with, payment in full is expected at each visit. Patients who do not supply accurate insurance information will be considered self-pay. If you are insured by a plan we are in-network with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2.Self-pay accounts. For patients without insurance coverage, patients covered by insurance plans in which J&R Pediatrics does not participate, or patients without an insurance card on file with us will be considered self pay patients and payment in full is expected at each visit.

3.Payments. We accept cash or credit cards (Visa, MasterCard and Discover). On a limited basis checks may be accepted and there is a service charge of $25 on any returned check;

4.Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

5.Non-covered services. Please be aware that some of the services you receive may be noncovered or not considered reasonable or necessary by the insurers. You must pay for these services in full at the time of visit.

6.Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

7.Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

8.Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

9.Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

10.Missed appointments. Our policy is to charge $25 for each missed appointment not canceled within 48 hours of the scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.
Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

The above information on all pages of this document is thorough and accurate to the best of my knowledge. For any changes to the above information, I will notify the office.

I consent to evaluation and treatment by any provider at J&R Pediatrics, PC.
I hereby authorize the release of medical information that is necessary for my further treatment.
I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services.
I authorize my insurance carrier to pay benefits for services rendered, directly to J&R Pediatrics, PC or any of its affiliates.
I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.
I have received and understand notice of privacy policies

I have read and understand the payment policy and agree to abide by its guidelines:

_____ _____

Signature of patient or responsible party Date

Name:_____

__I am the parent/guardian of this patient