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PEDIATRIC & ADOLESCENT MEDICINE

370 Grand Avenue
Suite 203
Englewood, NJ 07631
Phone: 201.568.3262
Fax: 201.569.2634

Patient Insurance Agreement

Dear Parent/legal representative:

In this age of managed care, with so many different insurance programs available, it is impossible for any doctor's office to keep up to date with each program's provisions. Because of the high cost of many problems associated with insurance companies and their lack of payment for the services we provide, there are certain patient responsibilities we must make you aware of.

Some carriers require that the patient notify them when they are admitted to the hospital.

You are responsible for all co-pays, all deductibles, all non-covered services or for any bills not paid. In addition, you are also responsible to know if you have co-pays for well care visits. The office will not reimburse co-pays made in error.

If your insurance company sends out letters questioning members for information before they will process their claims it is your responsibility to respond immediately. If you fail to do so, it could result in the entire bill becoming your responsibility.

It is vital to know which insurance is primary and which is secondary.

It is vital that you notify us immediately of any change of insurance, if you fail to do so, it could result in the entire bill becoming your responsibility.

You are responsible to know when you are eligible for services and to know your insurance coverage. It is your responsibility to notify us at the time of your visit if you need a referral, pre-authorization for any procedures, or specialist and if lab work needs to be sent to a special lab. Please understand that if we have not been advised in advance of your program's requirements and we provide a service or use a laboratory or hospital that is outside your program, YOU WILL BE RESPONSIBLE FOR THE APPROPRIATE FEES.

These are not our regulations. They are your insurance company's regulations and unless you follow them carefully, the insurance company may decline all or part of your claim. Your insurance carrier should have provided you with a phone number for you to use to obtain information about your coverage.

By signing this I acknowledge I have read the above information and understand what it says. My signature additionally serves as authorization to release any information necessary to process my child/children's medical claims and direct payment to the provider.
I permit copy of this authorization to be used in place of the original.

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_____

_____ _____
Signature of parent/legal representative Date

_____
Print name of parent/legal representative

Name(s) of child/children: _____