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Nanuet, NY, 10954

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Stony Point, NY, 10980



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Billing@clarkstownpeds.com

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BILLING POLICY of Clarkstown Pediatrics:

1. Guarantors, or legal guardians, who bring a child to our office for care are responsible for signing a financial waiver. This waiver assigns responsibility for payment of the day's medical services. By signing the waiver, a guarantor agrees to the standard protocol involved in billing an insurance company for reimbursement. It includes, but is not limited to, the release of information and assignment of payment directly to Clarkstown Pediatrics. All balances not covered by your healthcare insurance company are the full responsibility of the guarantor. Legal guardians must provide documentation for the child's medical record.
2. When children are scheduled for preventive care appointments (well child physicals or periodic health exams), it is the responsibility of the guarantor to verify insurance benefits before the visit. If your child's healthcare insurance does not cover routine services (i.e. tests, vaccines, or physicals) the balance is the guarantor's responsibility. **We cannot change billing codes once your healthcare insurance has been billed for a service.**
3. Copays are due at the time of service for each visit. Clarkstown Pediatrics charges for missed copays. Copays are part of our contractual agreement with your healthcare insurance company and are due at the time of service. We are prohibited from waiving any copayments by your healthcare insurance plan. All unpaid copays will be assessed an additional \$12.00 fee to cover our billing costs.
4. During a preventive care appointment, occasionally concerns are raised which require evaluation beyond the scope of a routine exam. The American Medical Association requires that coding be added to reflect which additional services were performed. These services and coding are not covered by healthcare insurance carriers as part of a well visit. They are subject to any copay, deductible, or policy restrictions that your healthcare insurance carrier determines. Our contract with your healthcare plan prohibits us from waiving any patient responsibility for these services.
5. Clarkstown Pediatrics accepts payment via cash, check, Visa, Mastercard, American Express or Discover card. Guarantors will be charged a \$25.00 service fee for any returned check. This fee will be in addition to the amount of the returned check.
6. Guarantors without healthcare insurance for their child's preventive care are considered "self-pay patients". They will be required to provide a minimum \$100.00 deposit for the day's services. If the Guarantor cannot provide this deposit, the visit will be rescheduled.

7. Certain Guarantors will be assigned to a "pay each visit" status. "Pay each visit" status applies to those accounts which have been turned over to a collection agency, those in which bankruptcy has been declared, those who have had their balances written off due to bad debt, or those who have a current large balance due. These Guarantors will be asked to make a \$100.00 deposit prior to their visit.

8. All balances are due within 30 days of the first billing statement. If you are unable to pay the balance in full within 30 days, please contact our Patient Account office to make payment arrangements. If more charges are added to the balance, new payment arrangements will need to be made. Delinquent accounts more than 90 days past due with no payments and/or broken payment arrangements are subject to collection activity including small claims court or collection services and dismissal from the practice. Guarantors will be notified in writing and by phone prior to any action.

9. It is the responsibility of all Guarantors to provide Clarkstown Pediatrics with valid healthcare insurance information at the time of service. Any Guarantor who does not provide correct insurance information at the time of service will be considered "self-pay" and the Guarantor will be responsible for the entire bill. Our office staff will ask for a copy of your healthcare insurance card at each visit (due to rapidly changing coverage issues and identification numbers).

I have read and understand the Clarkstown Pediatrics' Billing Policy. I agree to assign benefits to Clarkstown Pediatrics whenever necessary. I understand by providing Clarkstown Pediatrics any cell phone number constitutes permission to Clarkstown Pediatrics for that contact number to be used in the efforts of any communication. I also agree that if it becomes necessary to forward my account to a collection agent, in addition to the amount owed, I shall also be responsible for the costs of collections, including costs, fees and any percentage contingency fee.

I hereby agree to all policies listed and accept financial responsibility as Guarantor for the child or children I present for treatment to Clarkstown Pediatrics.

Guarantor Signature

Date

Printed Name

Children- Date of Birth