

**BRIARCLIFF PEDIATRIC ASSOCIATES, P.C.**  
**755 No. Broadway, Suite 500**  
**Sleepy Hollow, N.Y. 10591**

**FINANCIAL POLICY**

We would like to thank you for choosing BRIARCLIFF PEDIATRIC ASSOCIATES, P.C. and allowing us to provide your healthcare needs. The policies listed herein have been approved by the management with the goal of providing the finest care and service to our patients.

Care delivered by this facility will be administered regardless of race, color, creed, social status, national origin, handicap or sex.

We are committed to providing you with the best possible care. In order to accomplish this, we will request that you read and understand your financial responsibility and our payment policies.

**RESPONSIBILITY FOR THE BILL**

It is the expectation that all patients/guarantors receiving services are financially responsible for the timely payment of all charges incurred. While BRIARCLIFF PEDIATRICS will file claims for insurance policies as a courtesy to the patient, it is the responsibility of the patient to keep the office up to date with their most current insurance information. The patient/guarantor is ultimately responsible for payment and agrees to pay the account(s) in accordance with the regular rates and terms of BRIARCLIFF PEDIATRICS in effect at the present time. Payment will be accepted in cash, checks, Master Card, Visa, American Express or Discover.

**COPAYS**

All copays owed by patient/guarantor per your insurance company ARE DUE AT THE TIME OF SERVICES. If a copay is not paid at the time of service, a charge will be incurred.

**BROKEN APPOINTMENTS**

A block of time is allocated for all physical appointments. It is our office policy that a 24 hour cancellation notice is required for all physical appointments. If the office does not receive a 24 hour notice, there will be a service fee incurred.

## ACCEPTANCE OF INSURANCE

BRIARCLIFF PEDIATRICS will accept "Assignment of Benefits" on any insurance this office participates in and submit a bill to the carrier on the patient's behalf. It is understood that insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility. Claims filed will be held 45 days pending payment. The patient/guarantor will be responsible for payment in full on all claims not paid within the allowed period of time.

## VERIFICATION OF INSURANCE

Because of the wide range of insurance plans in effect, BRIARCLIFF PEDIATRICS will attempt to verify insurance coverage, deductibles and other limits, prior to acceptance for payment of services.

## OUTSTANDING BILLS

Once your insurance company has paid for a claim and balances are transferred to guarantor, payment is expected within 30 days, unless other satisfactory arrangements have been made with BRIARCLIFF PEDIATRICS. A 15% service charge will be incurred on all outstanding balances after 60 days.

## BAD DEBTS/LEGAL ACTION

If the account is not paid in full or satisfactory arrangements have not been made within the allowable time frame, BRIARCLIFF PEDIATRICS reserves the right to refer the account to an attorney and/or a collection agency for collection of the balance along with a processing fee.

## REJECTED CLAIMS

Our staff is trained to assist you with insurance questions. **COVERAGE ISSUES** can only be addressed by your employer or group health administrator. Although our assistance is available, we cannot act as a mediator on your behalf.

## PRE-ADMIT ARRANGEMENTS

BRIARCLIFF PEDIATRICS may request deposits against the total of charges in cases where the patient does not have insurance, proof of insurance, insufficient insurance, or the insurance does not cover the procedure.

**PRE-CERTIFICATION/REFERRALS**

**BRIARCLIFF PEDIATRICS** will make every effort to pre-certify all services and procedures requiring same, provided **BRIARCLIFF PEDIATRICS** is supplied with the necessary information. At least 48 hours is necessary for all pre-certification/referral procedures.

**RELEASE OF INFORMATION**

By signing our release of information form, you provide us with the authority to release such information as is necessary to collect from insurance companies and other third party payers.

The Administration and Management welcomes the opportunity to discuss any aspect of the financial policy. We appreciate your confidence and strive to provide quality healthcare.

**FAMILY NAME:** \_\_\_\_\_ **CHILDRENS' NAMES** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_