# Cohen & Sheinker MD PA

**FINANCIAL POLICY**

Thank you for choosing our office to provide care for your child (ren). In order to provide you with the best medical care and treatment and to prevent any misunderstandings, we ask that all parents read and sign our Financial Policy. If you have any questions, please ask our office manager or a representative from our business office.

As a courtesy we will verify your insurance eligibility and benefits at your initial visit and any time you notify us of a change in your coverage. However, we cannot guarantee that the information we receive is accurate at the time of verification or for later visits or that the insurance company will process the insurance claim in accordance with the information that they provided.

You, as the holder of the insurance policy, are ultimately responsible for knowing what your insurance plan does and does not cover (i.e. sick visits, well check-ups, immunizations and certain procedures). You are also responsible for verifying that your doctor is participating in your insurance plan. **Any amounts not covered by your insurance policy are your financial responsibility!**

**PLEASE READ AND INITIAL EACH ITEM BELOW TO CONFIRM THAT I UNDERSTAND THE FOLLOWING:**

____ **1. COPAYS AND/OR COINSURANCE AMOUNTS ARE DUE AT EVERY VISIT.** Our office accepts AMEX, MasterCard, Visa and Discover cards, checks and/or cash at the time of each visit. All copays are due at the time of your visit for each child being seen. If you have a deductible to meet, it is your responsibility to pay those charges once they have been submitted to your insurance. Not all services are a covered benefit in all contracts. Any balances billed to you are your responsibility.

____ **2. NEW INSURANCE/CHANGE OF INFORMATION** must be provided at the first visit after the effective change. You must provide this information before your child (ren) are seen. Failure to provide this correct insurance information will result in you being responsible for payment in full at the time of service.

____ **3. BALANCES OVER 60 DAYS OLD** will be given a notice of non-payment. We will charge the credit card left on file for your account. If the credit card is denied and payment is not received in full, or a payment plan is not setup through our in-office autopay system within 30 days, this will result in your account being turned over to a collection agency. In addition your child (ren) will be dismissed from the practice and you will have 30 days to find a new physician.

____ **4. CHANGES IN ADDRESS OR TELEPHONE NUMBERS SHOULD BE PROVIDED IMMEDIATELY.**

____ **5. RETURNED CHECKS** will incur a $50.00 fee. If a second check is returned on your account, checks will no longer be accepted as a form of payment towards your account.

____ **6. FEES SPECIFIED IN THIS POLICY** are subject to change with or without prior notice and will be applied to your account at the current rate.

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my child (ren)'s accounts for any professional services rendered. I have read all of the above information and understand it fully. I will notify this office of any changes in medical insurance or any other personal information that I have provided on the registration forms. I certify this information is correct to the best of my knowledge.

I hereby authorize the physician to furnish information to the insurance carrier concerning medical services rendered. I also authorize the insurance carrier to make payments directly to this office. I understand that I am responsible for any amount not covered by insurance. I agree to pay all balances due in full within 10 days of receiving a statement unless arrangements have been made in advance. Please sign below to acknowledge that you read and understand the financial policy of Cohen & Sheinker MDPA and that a copy has been placed in your records.

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**PARENT/LEGAL GUARDIAN SIGNATURE** **DATE**

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**PRINT PARENT/LEGAL GUARDIAN'S NAME**