Manhattan Pediatric Associates, P.C.

Financial Policy

Patient Name: _____ Date of Birth: _____

- It is the patient's responsibility to understand and know the terms of his or her insurance coverage (including eligibility, PCP assignment, co-insurance, deductibles, copay amount, number of well child visits allowed per year, etc.) and to monitor compliance with the limits of the plan
- Patient will be held responsible if services exceed the limits of the plan or for services not covered (ex. in-house lab, hearing screenings, and visions screenings) or deemed not medically necessary by the insurance.
- It is the patient's responsibility to designate doctors in our practice as their PCP, if required. Otherwise, patient will not be seen or will be considered a self-paying patient.
- All copayment is due at the time of service. This is a requirement of your insurance company.
- All deductibles and coinsurances are due at the time of service. If the exact amount cannot be determined at the time of service, a deposit of the approximate amount must be paid at that time. Any remaining or outstanding balance shall be billed to the patient once the explanation of benefits (EOB) is provided by the insurance plan. If the deposit exceeds the designated amount, payment will be refunded to patient.
- Patient, without insurance or whose insurance cannot be verified or is being seen as out-of-network, will be responsible for payment at the time of service.
- Patient will need to provide our office with the most current insurance info or card. Otherwise, patient will be considered as self-paying and be subject to payment at the time of service.
- When parent(s)/legal guardian(s) ask their designated caretakers to bring their child to our practice for medical care on their behalves, parent(s)/legal guardian(s) shall be financially responsible for all medical services rendered.
- The responsibility of payment for medical services provided to any dependent child whose parents are divorced rests upon the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of the practice.
- Payment of outstanding balances is due upon receipt of notification from our office. Please note that an interest will be charged for unpaid balances over a period of 60 days.

I have read, understood, and accept the above financial policy.

Signature of parent/guardian: _____

Printed name of parent/guardian: _____

Relationship to Patient: _____ Date: _____

Manhattan Pediatric Associates, P.C.

Office Policy

Hearing and Vision Screenings:

Hearing and vision screenings are considered an essential and necessary part of well child care visits and must be performed at least annually. It is the patient's responsibility to know whether or not the services are covered by their insurance policy. In the event that patients do not want a hearing (OAE) or vision (refractive test) screening to be rendered in our office, please inform our office in writing prior to the date of service or sign our hearing and vision agreement form in the office on the date of service. Please note that school forms cannot be completed without the submission of hearing or vision screening results from a licensed audiologist, otolaryngologist, ophthalmologist, or optometrist.

School and Other Medical Forms:

Our office will provide up to three school/medical forms free of charge per calendar year (January-December). Any additional forms are subject to $10 per form. Please allow at least one week for the form(s) to be completed and longer if it is school form season. We aim to return forms to you as soon as we can. We regret to inform you that forms will not be accepted nor returned via fax or email due to HIPAA regulations. Please submit forms in person or by mail. We cannot be responsible for any lost mail. Please call our office to confirm that we received your forms. Patients can send a self-stamped and addressed envelope to our office if one is unable to pick up the form in person.

I have read, understood, and accept the above office policy.

Patient Name: _____ DOB: _____

Signature of parent/guardian: _____

Printed name of parent/guardian: _____

Relationship to Patient: _____ Date: _____