

WESTSIDE PEDIATRICS P.C.

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WELCOME TO WESTSIDE PEDIATRICS P.C.!!!

We ask that when you come for your child's first visit you have some information available for us.

We participate with Oxford (freedom plan only) and United Healthcare. Because so many plans exist it is difficult to know every benefit a plan offers. Please phone your insurance company and find out the following information for us...

- Do Westside Pediatrics' pediatricians participate with your insurance company? This information affects your benefits.
- Does your insurance cover "well child exams"? If yes, are there any limits or exceptions and is there a co-pay attached to the well child exams?
- Does your insurance cover routine immunizations? If yes, is there a maximum amount that they will cover and/or are there any exceptions?
- Are routine lab procedures covered by your plan? If yes, which laboratories are considered participating?
- Do you have a deductible to meet? If yes, what is it and how is it calculated? If *no*, do you have a co-pay and what is it?
- If you have two insurances please find out if they both honor the "birthday rule"?
- Is the child's insurance active? Did you add your child to your insurance?
(If the child/children are not added to your active insurance at the time of the visit, you will be responsible for all charges incurred.)

☛ If you should have any questions, please feel free to contact our office in advance.

212-874-4500/office

☛ Enclosed you will find a copy of our financial policy and chart information sheet.

☛ Please complete and fax back the paperwork prior to your child's first office visit.

212-874-9046/fax

Please remember, it is your responsibility to have an understanding of the benefits your insurance company offers. Again, welcome to our practice. ☺

PATIENT NAME _____ D.O.B ___/___/___ GENDER _____
ADDRESS _____ Apt. _____ City _____ State _____ Zip _____
PHONE NUMBER (____) _____

> What hospital was your child born in? _____

PARENT'S NAMES

Father's Name _____ Mother's Name _____
Employed by _____ Employed by _____
Home Telephone (____) _____ Home Telephone (____) _____
Work Telephone (____) _____ Work Telephone (____) _____
Address (If Different From Child) _____ Address (If Different From Child) _____

Emergency Contact _____
Relationship _____ Home (____) _____ Work (____) _____

WHO RECEIVES THE BILL? (Responsible Party) Billing Name _____
Billing Address _____

INSURANCE

Policy Holder _____ Policy Holder SSN _____
Relationship _____ D.O.B ___/___/___
Insurance Co. Name _____ Insurance Co. Address _____
Policy Number _____
Group Number _____
Co-pay Amount _____ Policy Eff. Date ___/___/___ Phone Number (____) _____

Assignments of Benefits

I, the undersigned, request that payment of all insurance benefits payable for medical services provided, be made directly to the physicians of Westside Pediatric P.C. In-addition, I authorize the release of any medical information, as permitted by the law necessary to process a health insurance claim form.

Parent/Guardian
Sign _____ Print Name _____ Date _____

Beneficiary Agreement

I do hereby acknowledge that I was informed that in the event that my healthcare insurance plan denies payment for services received at Westside Pediatric P.C. I agree to be personally responsible for the payment of these services. It is therefore my responsibility to contact my insurance carrier to confirm the coverage provisions.

Parent/Guardian
Sign _____ Print Name _____ Date _____

Please be advised that a \$25.00 fee may be charged for failure to appear for an appointment without a 24hr notice of cancellation. Initial _____ and date _____.

Westside Pediatrics P.C. (FINANCIAL POLICY)

We are doing everything possible to hold down the cost of medical care. You can help a great deal by eliminating the need for us to bill you. The following is a summary of our payment policy.

ALL PAYMENT IS EXPECTED AT THE TIME OF SERVICE

Payment is required at the time services are rendered unless other arrangements have been made in advance. This includes applicable coinsurance and co-payments for participating insurance companies. Westside Pediatrics P.C. accepts cash, personal check (in-state only), American Express, VISA and MasterCard. There is a service charge for returned checks.

Patients with an outstanding balance of 60 days overdue must make arrangements for payment prior to scheduling appointments.

INSURANCE

We currently participate with Oxford (freedom plan only) and United Healthcare. You are expected to pay your deductible and co-payments at the time of service. If we do not receive payment from your insurance company, you will be expected to pay the balance in full. You are responsible for all charges.

We do not bill secondary insurance companies or insurance companies we do not participate with and/or not except assignment from.

Your time of service receipt includes all information necessary for submitting claims to your insurance company.

If you need assistance or have questions, please contact the Billing Coordinator between 9:00 a.m. and 4:00 p.m., Monday through Friday at 212-874-4500.

REFUNDS

Overpayments will be refunded upon written request to the responsible party within 30 days.

MANAGED CARE

If you are enrolled in a managed care insurance plan (i.e., HMO), you must receive a referral from our office before seeing a specialist. **NO** retroactive referrals will be given.

MISSED APPOINTMENTS/LATE CANCELLATIONS

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. We reserve the right to charge for missed or late canceled appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

I have read and understand the Westside Pediatrics P.C. Financial Policy. I agree to assign insurance benefits to the Westside Pediatrics P.C. practice whenever necessary. I also agree that if it becomes necessary to forward my account to a collection agency, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections.

Signature of insured or Authorized representative: _____

Print Name: _____ Date: _____

Patient: Name: _____

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