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## **OFFICE/BILLING POLICIES**

In order for our office to provide you with the best service possible, it is necessary that our office policies and procedures outlined below be understood and followed. As the guardian of a patient in our practice, please review and become familiar with these policies and procedures.

### **APPOINTMENT SCHEDULING:**

Please call our office between 9:00 am - 4:30 pm to schedule an appointment. If you leave a message during these hours, a staff member will call back promptly. Call the Emergency line ONLY in the event of an actual emergency. Walk-in patients without a scheduled appointment will be seen once ALL scheduled patients have been seen, UNLESS it is an emergency.

Our office schedules same-day sick appointments. Allow 3-4 weeks when scheduling well visits; 8-12 weeks during camp and back-to-school seasons. Well visits should be cancelled/rescheduled at least 24 hours prior to the appointment. If canceling with less than 24 hours notice, same day cancellations/no shows will incur a \$50 processing fee due by you.

### **INSURANCE/PAYMENTS:**

You are responsible for providing our office with complete, accurate and up-to-date account information including address, phone number and general billing information.

You are responsible for determining whether our providers are considered in-network for your particular plan. You are also responsible for verifying covered services as well as proper plan enrollment, including well visit and vaccine restrictions/limitations. This is not our responsibility nor will our office be responsible for non-covered services. You are responsible for providing both primary and secondary (if applicable) ACTIVE insurance at the time of the visit. If you do not have an insurance card at the time of the visit, you must contact your insurance provider to obtain the correct active member id(s).

If the patient is covered under an insurance plan with which our office participates, YOUR COPAY IS DUE ON THE DATE OF SERVICE. To stay in compliance with our insurance contracts, collecting copays on the date of service is required. If the patient is presented to the office by someone other than you, that individual is expected to remit payment on your behalf. We are requesting you keep a secure credit card on file authorizing payments to be processed on the date of service for this purpose.

If the patient is covered under an insurance plan with which our office does NOT participate, PAYMENT IN FULL IS DUE ON THE DATE OF SERVICE. Our office will provide you with a paid receipt to be submitted to your insurance for direct reimbursement.

Statements of balance due (for deductible, coinsurance and non-covered charges) will be mailed upon claim processing by your insurance carrier. Unpaid statements will subsequently be mailed on a monthly basis, however, our terms are set as due upon receipt. Late fees will be assessed and delinquent accounts will be forwarded to an outside collection agency. Please contact our office to make payment plan arrangements in the event of financial hardship. If you have an outstanding balance, please resolve this balance prior to scheduling any additional appointments. Again, please contact our office to arrange a payment plan, if necessary.

We accept the following payment methods: cash, check, money order or credit card (Visa, Mastercard and AMEX). We are requesting you keep a secure credit card on file authorizing payments to be processed on the date of service and/or the date of claim processing to eliminate paper billing. Returned checks will incur a \$25 processing fee due by you and a personal check will no longer be accepted for future balances.

#### **MEDICAL RECORDS:**

Requests for records (medical record transfers, school/camp/forms, etc) should be presented to the office in writing and will incur a \$10 processing fee due by you upon release of the records. Records in excess of 40 pages will incur additional fees. Account balances should be paid in full at the time of release, unless the release is approved by one of our providers and/or a previously arranged payment plan is in effect.

Prescriptions called in after-hours (evenings/weekends) will incur a \$25 processing fee due by you.

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- ☐ I have read, understand and will comply with the Brooklyn Bridge Pediatrics office and billing policies.
  - ☐ I understand my financial responsibility for balances due for deductibles, coinsurance, non-covered services and office fees.

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Signature of Insured or Financial Guarantor

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Date

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(Print) Name of Insured or Financial Guarantor

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Relationship to Child

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Child's Name(s)