Princeton Endocrinology Associates, LLC

10 Forrestal Road South
Suite 106
Princeton, NJ 08540

(609)921-1511
FAX (609)921-3316

Patient Name_____ Birthdate_____

Financial Policy

Along with providing quality healthcare to our patients, it is very important to explain the financial expectations of the doctor/patient relationship. If you have any questions regarding our policy, please feel free to speak with our Office Manager.

Billing your insurance: As a courtesy to you, we will bill your insurance carrier for services provided. We assume no responsibility for services denied by your carrier. We encourage you to call your benefits representative to verify coverage before receiving services. In the event your claim is denied, we will do the following:

A. Determine from the explanation of benefits (EOB) if the reason for denial was an error on our part. (For example, wrong identification number entered, incorrect diagnosis code, etc…) If the error is ours, we will correct the claim and resubmit it immediately. If the denial is due to no fault of our own (for example, noncovered benefit, no referral on file, coverage terminated) we will send you the bill. **Please do not ask us to change a diagnosis code in order for the claim to be paid. This is illegal and is considered fraud and abuse.**
B. Once the claim is determined to be correct and not payable by your insurance company, we will notify you and expect payment within 30 days.
C. After 30 days, your claim is considered past due. After 90 days past due, we will charge a 1.5% interest rate to your balance, per month until paid in full.
D. After 90 days and you account remains past due, we will consider and most likely refer your account to a credit bureau or collection agency. At which time, you will also be responsible for any collection fees incurred.

We encourage you to communicate with us if you are having financial difficulties as early as possible. Our goal is not a financial one, however, we also have many expenses that are necessary in order to remain in business. We will be happy to make a payment arrangement with you so that your debt is more manageable.

Referrals: If you have an HMO, please bring a referral and/or authorization number with you at the time of your visit. If you do not obtain one prior to your visit, you will be asked to sign a waiver claiming responsibility in the event the claim is unpaid. We will not bill your insurance without one. Please note: understanding your insurance policy and obtaining referrals should you require one from your PCP is your responsibility.

Copays: Please be prepared to pay your copay at each visit. The amount of your copay is usually indicated on your insurance card. For your convenience, we accept all major credit cards, cash, and personal checks.

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Deductibles: If you have not met your deductible, you will be billed for the service provided and payment is expected at the time of service. You are responsible for this payment regardless of any insurance company's determination of usual and customary rates.

Non-Participation: If you have a health insurance card with a plan in which we do not participate, we will be glad to give you the documentation that may allow you to obtain reimbursement from your health insurance provider. However, payment for today's visit is expected at the time of service.

Insurance Card: Please show your insurance card at every doctor's visit. If you do not provide us with your card, we are unable to bill your insurance for the service.

Returned Checks: All returned checks are subject to a $25.00 fine.

No Show Policy: We have set aside a specific amount of time especially for you, and without 24 hours notice we are not able to fill your scheduled time slot. Therefore, you will be billed for appointments cancelled with less than 24 hours notice. The fee will be in accordance with the level of service. **You will be charged $100.00 for an initial visit and $50.00 for a follow up visit.** Insurance companies do not reimburse for these fees, therefore, you will be responsible for the full charge.

I have read and fully understand this financial policy. I also understand that Princeton Endocrinology Associates, LLC and/or its designee can turn my unpaid account over to a credit or collection agency in an attempt to collect a debt.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date