



Financial Policy

Thank you for choosing Bridgespan Medicine as your child’s health care provider. Please be assured that your child’s health care is of the utmost importance to us. Your clear understanding of our Financial Policy is important to our professional relationship with you. This policy will serve as a guide to our policies and help with any questions about your financial obligations.

Insurance

Bridgedpan Medicine participates with most insurance plans. To properly bill your insurance company, we require a copy of your (or your dependent’s) insurance card. It is your responsibility to inform us of as any change of insurance. Failure to provide complete insurance information may result in patient-responsibility for the entire bill.

Co-Payments

Contractual obligation with your insurance plan requires us to collect a co-payment. All co-payments will be requested at the time of the service. There will be a \$20 surcharge applied to your account if your co-pay is not paid at the time of service. We accept cash, credit cards or check. There is a \$50 fee for any check returned to us from your banking institution.

Self-Pay

Payment is expected at the time of the visit unless other arrangements have been made with the office manager prior to the visit. We accept cash, credit cards or check. There is a \$50 fee for any check returned to us from your banking institution.

Non-covered Service

We will always provide your child with what we consider medically necessary based on the guidelines of the AAP. As a result, certain services provided to your child may not be reimbursed by your plan. These services will be the responsibility of the policy holder/parent.

No Show/Late Cancel Policy

A \$75 surcharge will be applied to your account if you (your dependent) do not arrive for an appointment and do not cancel 24hrs prior to the scheduled appointment.

Laboratory Services

We will send your lab work to the preferred laboratory based on the insurance information you have provided to our office. We are not responsible for balances due from outside labs. These services will be the responsibility of the policy holder/parent.

Camp/School Forms

There will be a \$10 charge for any forms. You can request a NY State Health Appraisal form at no cost.

I acknowledge full responsibility for services rendered by Bridgegespan Medicine, PLLC. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance. I understand that co-pays are due at time of check-in; otherwise, the applicable co-pay charge will be applied to my account.

I authorize Bridgespan Medicine to release information to Medicare/other insurance carriers responsible for my dependent’s care. I request that payment of authorized Medicare other insurance company benefits be made either to me or my behalf to Bridgedpan Medicine for any service rendered.

I, _____ understand that it is my responsibility to select Dr. Avvocato, Dr. Chen, Dr. Kelleher, Dr. Woo or Dr. Wurzel.

Signature of Parent /Guardian _____ Date: _____