Holmdel Pediatrics L.L.C.
719 N. Beers St., Suite 1E
Holmdel, NJ 07733

Financial Policy

Our Financial Policy is dedicated to providing you with the best possible care, services and helping you receive insurance benefits for which you are fully entitled.

Insurance:

We participate with several insurance companies. Please check with the Billing Department to see if we participate with your plan.

If we DO participate with your insurance company, all services performed in our office and at the hospital will be submitted to them, unless we receive prior notification of non-covered services. All copays, co-insurance and deductibles are the patient's responsibility and will be billed to you by our office. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

While filing of insurance claims is a courtesy that we extend to our patients, all charges are strictly your responsibility from the dates of service rendered. Therefore it is necessary for you to inquire and explore your benefits with your insurance carrier. Please contact your insurance regarding COB (Coordination of Benefits): failure to do so will delay payment of your insurance claims.

If we Do Not participate with your insurance company, this means that we will not bill your insurance carrier. Any balance becomes your responsibility.

It is important for you to understand that your health insurance coverage is an agreement between you and your insurance company and you doctor's bill for the services provided to you is an agreement between you and your Doctor

Payment for services performed:
Our office accepts Visa, Discover and Mastercard for your convenience, as as cash or check. All payments are expected at the time of service and any outstanding balance are due within 30 days, unless prior arrangements have been made with the Billing Department. All past due balances are assessed 1.5% per month finance charge after 60 days. All balances that reach 90 days past due will be sent to Collection Agency and late fee of $20.00 will be applied. You will be responsible for all collection fees and legal fees that our office incurs through the process utilized to collect the outstanding delinquent balance.

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY AND I AGREE TO THE TERMS OF THIS FINANCIAL POLICY. I ALSO UNDERSTAND AND AGREE THAT THE TERMS OF THE FINANCIAL POLICY MAY BE AMENDED BY THE PRACTICE AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE PATIENT.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Print name of Parent/Guardian Patient

D.O.B. _____