Gomathi Pediatrics PLLC
67 North Main Street, 2nd Floor
New City, New York 10956
Tel: 845-634-8911
Fax: 845-634-9002

FINANCIAL POLICIES

Our goal is to provide you with high quality and efficient care. There are many details involved in the process of payment for the services that you receive. In order for this process to flow smoothly, it is essential that you understand what information we must share with each other and with health insurance companies, and what both our responsibilities may be.

We require information about both the patient and the guarantor both for our records and in order to properly process insurance claims. Please provide our staff with all the information requested of you.

Health Insurance Cards: Our staff will need to verify your insurance information for each appointment. Please notify us should your insurance change. Intentionally failing to notify us of changes to your insurance coverage may constitute fraud, and we may be obliged to report such behavior to the authorities. We will not engage in any fraudulent practices under any circumstances.

Keeping Appointments: It is very important to us that all our patients get the care they need, and that appointments are available to patients who desire them. ***Therefore we have implemented a $25 service charge for no-showing sick visit or recheck appointments and $50 for no showing well visit appointments***. The fee will be charged for appointments not cancelled at least 1 full business day in advance for recheck or well visits and 2 hours in advance for same day sick appointments. Additionally, should you arrive more than 15 minutes late for an appointment without checking with us by telephone in advance, your appointment time is forfeit, and while we will work you into the schedule as circumstances permit, you will be charged as a no-show if you elect to leave.

Health Insurance Plans: While insurance plans can be difficult to understand, it is very important that the patients (and guarantor) understand the provisions of your health insurance plan and coverage. We deal with scores of insurance companies that each have several different plans and cannot be expected to know the details of your particular plan. We therefore recommend contacting your insurer prior to receiving services in order to verify your coverage levels and out-of-pocket responsibilities.

Copayments: It is our responsibility to collect any copayment amounts at the time of your appointment. It is your responsibility to pay any copayment amounts at the time services are rendered. Please have your copayment ready upon check-in. As it costs as much to bill for a co-pay as most co-pays are worth, should you be unable to make your copayment at the time of service you will be responsible to pay an invoice fee in the amount of $20 for each instance we send you an invoice for an unpaid copayment (except for Federal & State plan beneficiaries), including multiple invoices for the same date of service. If your plan has separate copayments for different types of service, this policy applies to each copayment, depending on services rendered on that date of service.

Previous balances and/or deductibles: It is our responsibility to bill you for any portion of your treatment that your health insurance carrier assigns to your responsibility. It is your responsibility to pay any such portion in full and on time. If you do not make full payment on any such bills within a reasonable period or set up a payment schedule with us, we may need to turn your account over to a collection agency and/or legal action will need to be pursued. If your account is turned over to a collection agency, a fee of $30 per date of service will be added to the charges. In addition, you may be dismissed as a patient by our practice for failure to meet your financial obligations.

Health insurance non-payment: Services that have not been paid by the patient's health insurance carrier within 90 days of claim submission will become his/her responsibility to pay in full. Should the health insurance carrier later pay us for those services you paid for, a reimbursement will be issued to you within 30 days.

Financially Responsible Party: While we care deeply about the welfare of our patients, we cannot become involved in any financial disputes or financial arrangements between patient guardians. Our policy is that the parent or guardian who brings the patient in for his/her care is financially responsible for all charges that the patient is responsible for. Upon request we will issue duplicate receipts, so that one guardian can apply to the other for reimbursement, but we will not split invoices.

Self-pay patients: If you do not have health insurance, we expect payment at the time services are rendered. Uninsured patients who would like to discuss discounted rates, or who need to set up a payment, must do so prior to receiving services. Just let us know when you call to make your appointment and we will be pleased to work with you.

I have read, fully understand, accept and agree to comply with all the above policies. I consent to the assignment of authorized health insurance benefits by my health insurer to Gomathi Pediatrics PLLC for any services furnished to me and/or my dependents.

Patient Name (Please print clearly): _____ Date: _____

Signature of Parent/Guardian: _____ Relationship to Patient: _____

If the patient is of age 18 or older, the patient him/herself must sign this form, and "Self" should be written in the Relationship slot.