TRAVEL HEALTH AND INFECTIOUS DISEASE LLC

395 PLEASANT VALLEY WAY, WEST ORANGE, NJ 07052

Financial & Office Policy – Effective 12/1/2012

Dear Families,

In the interest of good healthcare practice, it is desirable to establish a financial policy to avoid misunderstandings. Our primary responsibility is to help our patients experience good health and we wish to spend our time and energy toward that goal. Insurance reimbursement is a contract between you, your employer, and the insurance carrier. **YOU** are responsible for payment of your account. **YOU** are responsible to be aware of your benefits and to contact your carrier directly when issues arise regarding timely payment of claims or denials. Insurance(s) are gladly billed as a courtesy to our patients when current card(s) are provided to us. We cannot accept responsibility for follow-up on your claims or for negotiating a disputed claim.

The following policies must be agreed upon:

1. **All co-pays** are due at the time of service. A $25 charge will be added to your account if not within 24 hours. Non-urgent care may be subject to rescheduling when co-pay is not paid. Please do not ask us to waive co-payments; it is considered a breach of the insurance contract and it can lead to denial of payment by the insurance company.
2. **No-shows**: If you do not cancel your appointment in a reasonable amount of time (i.e. 24-hrs when scheduled in advance, or at least 2 hours prior when scheduled the same day) and simply fail to show up, a charge of 25$ will be added to your account
3. **We run a Zero Balance office**. All outstanding accounts are due and payable at the time of your visit, unless satisfactory arrangements have been made with us. All personal accounts past due more than 60 days from the date of billing will accrue a $10 monthly late fee. Accounts may be assigned to an outside collection agency and reported to the credit bureaus if the personal balance is over 120 days old. A $50 collection fee will be assigned to your account if sent to an outside collection agency.
4. **Insurance Payment**: We will bill the insurance companies we participate with; however,

if we are not paid in a timely fashion, you will be responsible for the bill and expected to pay in full. It is your responsibility not ours that your insurance company pays on time.

1. **Payment for travel related care and vaccines:** Most insurances do not pay for travel related vaccines. You are responsible for payment at time of visit for travel consultation services and vaccinations, before the services are rendered.
2. **We do not mail any prescriptions, completed forms, excuse notes.** These forms need to be picked up at our office in person.
3. **Returned check**: A $25 charge will be added to accounts for each check that is not honored by your bank. If two checks are bounced, we will not accept checks for payment on your account.
4. **Referrals:**If your insurance contract requires a referral for consult or treatment by a specialist or for ancillary services such as radiology procedures, you must receive the referral from your PCP’s office before seeing a specialist. Self-referrals willbe considered as out-of-network care by a specialist and may result in financial liability to the patient. Travel Health and Infectious Disease, LLC cannot accept responsibility for patient’s non-compliance with their individual insurance policies.
5. **Patient Satisfaction**: Our policy is to make your experience an exceptional one. When we succeed, we would appreciate you telling your family and friends about our offices.

**Acknowledgement of Receipt of TRAVELHEALTH AND INFECTIOUS DISEASE, LLC’S**

**Financial & Office Policy 12-01-2012**

I have read and understand my financial obligations. I understand that I am personally responsible for this account regardless of medical insurance, divorce decree or otherwise. I understand that in the event this account becomes delinquent, by affixing my signature hereto, I am bound and responsible for all charges upon this account. I further understand that delinquent accounts may be assigned to a collection agency and further reported to a credit bureau. In the unfortunate event that collection is necessary, the undersigned expressly agrees to pay all prevailing party attorney fees and costs.

**Receipt of Notice of Privacy Practices Written Acknowledgement Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of Travel Health and Infectious Disease LLC’s Notice of Privacy Practices.

Parent/Guardian/Patient

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Signature of Parent/Guardian/Patient Date