



Pediatric & Adolescent Medicine, LLP

Financial Policy & Administrative Fee Notice

Insurance & Billing

We participate with most plans from **Cigna, Oxford, UnitedHealthcare, Anthem Blue Cross Blue Shield, and Aetna**. You must provide current and active insurance information at each visit. If we do not participate in your plan, payment is due at the time of service. A detailed receipt will be provided for you to submit for reimbursement.

You are responsible for **co-pays, deductibles, co-insurance, and patient responsibility charges**, including telephone/portal/email encounters. During a Well Routine Physical Visit If a symptom or complaint is discussed and addressed (i.e.: provider writes a prescription, makes a referral to a specialist, orders labs or imaging,) a separate and billable service will be charged to your insurance and any applicable copays/deductibles or coinsurance, based on your benefits, will be billed to you.

Administrative Fee

Effective September 1, 2022, we will charge an annual Administrative Fee to cover these non-reimbursable administrative tasks and services. This allows us to continue to provide the most up to date services while remaining a small, private, personal, and accessible office. This fee may be subject to annual increases to be determined by the practice

The Administrative Fee allows us to optimize the wellness of your family by continuing to provide the following services:

- *Urgent/same-day sick visits*
- *Prescription refills & prior authorizations*
- *Coordination with specialists*
- *Unlimited medical record copies & patient portal access*
- *Forms for school/daycare/camp*
- *Evening/weekend hours & after-hours nurse/provider advice*
- *HIPAA-compliant digital forms*

Fee: \$350 annually for the first child, +\$50 for each additional child (max \$500 per family). This fee is not covered by insurance but may be eligible under FSA plans.

Patient Responsibility

- *Know your benefits (referrals, authorizations, covered services).*
- *Notify us promptly of insurance changes.*
- *Provide accurate insurance info at time of service.*



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No Show / Cancellation Policy

Please cancel/reschedule at least **24 hours in advance** by calling or emailing your office:

- **NYC:** 212-787-1444 | receptionist.nyc@pedsny.com
- **Scarsdale:** 914-725-7555 | receptionist.scarsdale@pedsny.com

Fees for missed/late cancellations:

- Well Visits: \$50
- Sick/Follow-up Visits: \$25
- Nurse/Vaccine Visits: \$25
- Same-day sick visit: No charge

Your credit card on file will be charged for missed/late-cancelled visits.

Credit Card on file Policy

Your signature below authorizes all outstanding balances accrued on your account at Pediatric and Adolescent Medicine, LLP to be charged on the Credit Card below:

For Credit Card Authorization:

Visa/Mastercard/Amex/Discover card: _____ Exp date: __/____

CVV: _____

Credit Card Holder: _____

Child/Children's name: _____

Signature

_____/_____/_____
Date



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Acknowledgement

I have read and understand my financial obligations and the above policies. By signing below, I acknowledge that I understand and agree to the financial, administrative, and no-show/cancellation policies of Pediatric & Adolescent Medicine, LLP. I also authorize PedsNY to charge the credit card on file if I fail to arrive for a scheduled appointment or cancel an appointment less than 24 hours in advance.

Patient Name: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____

Date: ____/____/____