Garden State Hearing & Balance Center

250 Route 37 West, Toms River, NJ 08755
Telephone: 732-818-3610
Fax: 732-818-3663

Financial Policy

What you should know about health insurance

What are my responsibilities as a patient?

All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

It is your responsibility to **provide our office with your complete insurance information** in a timely manner. Most insurance companies have filing deadlines as part of their contract with you or your company.

It is your responsibility to know your insurance company's patient responsibility and procedures.

It is your responsibility to follow up with your insurance and make sure they process payments in a timely manner.

Please note that our charges do represent the Usual and Customary Rates (UCR) for our geographical area and are based on the current Physician's Fee Reference, **but they may be higher than your insurance UCR**.

Outpatient Treatment

1. As a courtesy to you, we will submit a claim form to your insurance as soon as possible.

2. Once the claim has been submitted, you will receive a statement from our office showing the balance on your account. If your insurance company does not pay your balance in full **within 30 days** from date of submission, we will request that you **contact your insurance carrier to speed things up**.

3. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due in cash, personal check or credit card.

4. Balances **older than 90 days** may be subject to additional **collection fees and interest charges**. Returned checks will have additional fee of $25.00 added to the amount of the returned check.

5. Please note that your insurance policy is a contract between you and your insurance company. We are NOT a party to that contract. Our financial relationship is with you, not your insurance company.

6. Should payment be made from your insurance company to you, you are responsible for immediately sending payment, including any deductible and co pay to our office. Failure to do so will result in additional interests and/or collection fees.

7. **We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems to us so that we can assist you in the management of your account.**

Follow-ups / Office Visits

1. Normally, all necessary information will have to be obtained by our office staff prior to your first consultation or follow up visit. The information you share with our trained office staff will become part of your medical record and will be kept confidential. All patients/responsible parties should remember to bring:

   Picture Identification
   All active insurance cards.

2. Furthermore, all patients should come prepared to pay the patient share including co-pays, deductibles or self pay portion.

In cases of divorce, the parent/guardian who brings in the child/children for treatment is responsible for payment and for collecting from the other parent or attorneys. Thank you for your understanding in this matter.

Patient Signature: _____ **Date:** _____

Parent/Guardian (if minor):_____ **Date:**_____