



--a division of Allied Pediatrics
of New York, PLLC

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In order to accommodate the needs and requests of our patients, we have enrolled in numerous managed care insurance programs. However, due to evolution and mergers in the insurance industry, this practice does not participate in all insurance plans. Therefore, it is **your responsibility** to confirm that our practice participates in your particular insurance plan.

While we are pleased to be able to provide this service to you, it is extremely difficult for us to know all the individual requirements of each insurance plan. Each plan has different stipulations regarding how often services may be rendered, particularly how often your child may have a check up. Even within the same insurance company, individual plans may differ depending upon what type of contract your employer has negotiated.

Providing quality medical care for our patients is our primary concern; we are more than willing to provide that care within your insurance contract guidelines whenever possible *if you let us know at each time of service what those guidelines are.*

It is your responsibility, as the parent/insured, to be aware of the current terms of your insurance coverage. **All copayments, by contract, must be paid at the time of your visit. We reserve the right to charge an additional service charge—currently \$10.00—for any copay left unpaid on the date of service.** If your yearly deductible has not been met, this must be paid at the time of your visit. If you do not have insurance, or insurance we participate in, payment is expected at the time of service. For your convenience, we accept cash, check or credit cards.

If your insurance plan requires you to have a referral to see a specialist, you must coordinate getting that referral *prior to your appointment with the specialist.* In most cases, your insurer will require that we see your child for the particular problem *before we may issue a referral.*

If you do not inform us of any special requirements in your insurance contract and we subsequently order services such as lab work, x-rays, hospitalization, immunizations, etc., that are not covered by your insurance policy, you agree to be responsible for all charges related to these services. *Payment for these services is your financial responsibility.*

If services are provided and your coverage is not in effect or you have failed to provide us with the correct information to submit the insurance claim in a timely manner, *any fees submitted and denied will become your financial responsibility.*

With your cooperation and assistance, you should be able to receive all of the benefits offered to you and we will be able to concentrate on caring for your children’s medical needs.

I understand the office policy stated above and agree to accept responsibility as described above.

Parent signature _____ Date _____

Print name _____