Infectious Disease Center
of New Jersey

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FINANCIAL AGREEMENT

- I authorize the release of information necessary to any entities to secure the payment of benefits submitted for services rendered by Infectious Disease Center of New Jersey, L.L.C. on behalf of myself and/or dependents. I understand information will be provided to a contracted billing service, to secure the payment of benefits. I further agree and acknowledge that my signature on this document authorizes claims to be submitted for benefits for any services rendered without obtaining my signature on every claim form. I assign directly to Infectious Disease Center of New Jersey, L.L.C. insurance payments for all services rendered. Should the need arise, I also authorize Infectious Disease Center of New Jersey, L.L.C. to file a complaint on my behalf for any dispute or appeal regarding accurate and fair reimbursement for services rendered.
- **I understand I am financially and fully responsible for all charges incurred if my insurance carrier denies payment for any reason.** I understand I will be financially responsible for any deductibles, coinsurance or co-pays according to my individual benefit plan. I understand that a co-payment is due at the time of service. I understand that a delinquent balance must be paid in full prior to any scheduled appointments, unless prior payment arrangements have been made. I understand I am fully responsible for contacting my insurance company prior to services rendered, to determine if the provider participates with my specific plan, determine if any referral or pre-authorization is needed, and understand any coverage limitations. I understand I will be fully liable for any visits not covered under my plan for any reason. Any credits will remain on file and will be applied to future balances unless a refund is requested.
- In the event my insurance carrier issues a payment directly to me, I agree to reimburse the Infectious Disease Center of New Jersey, L.L.C. for the same amount paid to me, in addition to any co-pays, deductibles or coinsurances due based on the explanation of benefits. I agree to send in a check along with the explanation of benefits upon receipt of payment within 10 business days of receipt of payment.
- I agree to provide the Infectious Disease Center of New Jersey, L.L.C. with current insurance information and advise the office of any changes within 30 days from the date of service. I understand that if a claim is not paid because of my failure to provide the correct insurance information in a timely manner, I am fully responsible for the charges.
- I understand that payment is due upon receipt of my monthly statement. I understand that I will be legally responsible for all collection costs involved including attorney's fees that are 1/3 of all balances due and owing, collection filing fees, and any fees for returned checks.
- Patients are responsible for providing coordination of benefit information to their insurance carrier. This information must be sent to an insurance carrier directly from the insured and or patient. I understand I am fully responsible for coordinating benefits between my primary and secondary insurance carriers. I understand that if there is a discrepancy on file between the correct primary and secondary carrier, I am fully responsible for taking the necessary steps to correct this problem to allow reimbursement to Infectious Disease Center of New Jersey, L.L.C. In the event that this coordination of benefit is not resolved, I understand I will be responsible for any outstanding balances.
- **Cancellation policy**- our office requires 24 hour prior notice for all cancellations. If this notice is not received, I understand a $50.00 cancellation fee will be incurred. Payment is due upon receipt of the invoice.

I understand the above financial agreement. Please Sign below to accept this agreement.

Patient Name: ____

Patient / Guardian Signature ______________________________ Date: ___/___/_____