Financial Policy

Primary Care Associates of NJ, LLC
(973) 334-9404
(973) 334-7615 Fax

329 Main Road
Montville, NJ 07045

This is an agreement between Primary Care Associates of NJ, a Limited Liability Corp., as creditor, and the Patient/Debtor named on this form and supersedes any prior policy.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Primary Care Associates of NJ, LLC. By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the 1½% monthly finance charge and any payments or credits applied to your account during the month.

Payment option if you have no insurance:
1. You may choose to pay by cash, check, or credit card on the day that treatment is rendered, unless arrangements have been made prior to the appointment.

Payment options if you have insurance:
1. You may choose to pay your deductible/co-payment and any out-of-pocket portions at the time services are rendered by cash, check, or credit card.
2. You may choose to pay all of your treatment by cash, check, or credit card if you belong to an insurance plan we are not contracted with.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

Insurance: Insurance is a contract between you and your insurance company. We are NOT a party to this contract, in most cases. We will bill your primary insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

The financial policy continues on the back side of this page.

Your signature and initials on this document indicate that you have read and agreed to all policies and procedures outlined on this form. This includes but is not limited to authorizing PCANJ to charge credit card on file, or make electronic fund transfer as needed to cover any outstanding balance on your account.

Patient's name: _____
First Middle Last

Responsible party
(if not the patient): _____

Signature: _____ Date: _____
Social Security #: ___ - ___ - _____

Co-Signature: _____ Date: _____
Social Security #: ___ - ___ - _____

PRIMARY CARE ASSOCIATES OF NJ, LLC
Complete healthcare for the entire family

Revised 6/13/2016

Finance Charge: A finance charge can be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The **FINANCE CHARGE** will be computed at the rate of one and one half percent (1½%) per month or an **ANNUAL PERCENTAGE RATE** of eighteen percent (18%). The finance charge on your account is computed by applying the periodic rate 1½% to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is $.50.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Additionally, you will provide a credit card or checking account number at the time of service. This number will be used to directly transfer funds to PCANJ should your insurance not cover your visit, or for any balance not covered by your insurance. Failure to pay at time of service will result in a billing penalty charge of $25.00 per missed co-payment.

No Shows: Failure to cancel your appointment at 24 hours in advance of a scheduled appointment for routine, sick or child well care will result in a $30. fee being applied to your account. Failure to cancel your appointment at 24 hours in advance of a scheduled appointment an adult annual physical will result in a $45. fee being applied to your account. This fee is not payable by your insurance, and is your responsibility.

Returned checks: There is a fee (currently $25.00) for any checks returned by the bank.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we need to send past due letters and certified letters, your account will be assessed a charge of $25.00 for each letter sent, plus the cost of postage. In case of suit, you agree the venue shall be in Morris County, New Jersey.

Waiver of confidentiality: Authorization is given to release or receive any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit. You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently $1.00 per page, $10.00 minimum charge, not to exceed $100.00 per chart copied) if you want to have copies of your records sent to yourself, another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or workers compensation carrier prior to your initial visit. If your claim is denied, you will be responsible for payment in full.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this, or another Financial Policy, is signed by different person on the account, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

____ Initials