FINANCIAL/OFFICE POLICY FOR

JANET WESTENBERGER, D.O. P.C.

WELCOME

Thank you for choosing our medical office. We are committed to providing and maintaining the best possible care for our patients and your family. We provide equal access to all its patients regardless of source of payment. Your review of our office financial policy in advance allows for effective communication and enables us to provide the highest quality service to your family.

Each time you arrive at our office, we will ask to confirm your current insurance, address and contact information. Keeping your file updated keeps the lines of communication open in case we need to reach you regarding your health or your account.

At the time of each appointment, please provide your insurance card, current mailing address and copayment/coinsurance. If you have any questions or concerns, please contact our billing office at 716-639-0155 Monday through Friday 8:00am through 5:00pm.

YOUR INSURANCE

We participate with numerous insurance companies including all local insurance plans and many national plans. You are responsible for providing current or updated insurance information at each appointment.

If your plan requires, you may need to list Dr. Westenberger as your primary care physician (PCP). To prevent billing problems, you should do this prior to your first appointment. Please be aware that some insurance companies do not pay the entire doctor’s bill, therefore you may be responsible for some or all the bill.

You should be aware of your insurance coverage policy provisions, authorization requirements and network providers. You are responsible for obtaining and presenting prior authorizations if your insurance company requires it. Most insurance plans have a website or call center that can provide this information.

COPAYMENTS

We will collect your office co-payment at check in. We accept cash and checks. If we add credit card availability it will be posted.

During a visit to our office, patients may receive various kinds of services; each service may have a separate charge. By addressing new or established issues during a preventive care exam or “checkup”, we hope to avoid any inconvenience or additional visits. Your insurance company may require that you pay a copayment, coinsurance or deductible for these services.

HIGH DEDUCTIBLE PLANS

We will make every effort to know your high deductible status when you check in, through your insurance company website or HealtheLink. At a minimum, you may be charged $70.00 at the time of your visit.

NON-PARTICIPATING INSURANCE COMPANIES

If we do not participate with your insurance, we will submit claims on your behalf as a courtesy. If your insurance company does not pay within 45 days, you will be responsible for the balance.

Should we not participate with your insurance you will be requested to pay pre-estimated minimum amount of $70.00 for office visit services. Pre-collection amounts are estimates only as we are unable to determine services performed prior to being seen. You will be billed for any remaining amount due.

NON-COVERED SERVICES

If your health insurance company determines a service is “not covered”, you will be responsible for the complete charge. Should this occur, we will personally bill you for the service. Payment is due upon receipt of that statement.

WORKERS’ COMPENSATION AND NO FAULT

If you have sustained injuries in a work-related or motor vehicle accident, please notify us at the time of your appointment. All No-Fault and Workers’ Compensation information should be given to us at the time of first treatment. By law, No Fault claims must be filed within **45 days**. If you do not supply us with this information, you may be responsible for the entire payment. In the case of Worker’s Compensation accident, please notify you employer of the injury.

MINOR PATIENTS

Patients under the age of 18 require parental consent for any treatment or immunization except as permitted by New York State law. The parent/guardian accompanying the minor patient will be responsible for payment of all serviced rendered, whether the account is considered self-pay, participating insurance, or non-participating insurance.

PAST DUE ACCOUNTS

An account is considered past due if no payment is received within 30 days of the first account statement. Patients with past due accounts must make a payment before the next appointment with their health care provider. A statement fee of $5.00 will be added on subsequent statements. Accounts beyond 60 days past due are considered delinquent and may be forwarded to a collection agency.

You agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses we incur in such collection efforts including reasonable attorney fees we incur in such collection efforts.

PAYMENT ARRANGEMENTS

If you are unable to make full payment of the account balance when due, arrangements for a partial payment plan can be made with our billing office. Please call 716-639-0155 Monday through Friday 8:00am through 5:00pm. Note: There is a $5.00 per statement fee.

INSUFFICIENT FUNDS CHECKS

Returned checks will be charged back to the patient’s account. There will be an additional $37.00 service fee for each returned check. We reserve the right to require cash or money order for future payment on accounts with returned checks.

BILLING COMPANY

Our insurance and patient billing is handled by HealthTec Solutions. The staff at HealthTec Solutions works very closely with our office to ensure that your insurance is billed properly and that full reimbursement is received from your insurance company. For any questions regarding your account, please call HealthTec Solutions’ staff at 716-639-0155 Monday through Friday 8:00am through 5:00pm.There will be a $5.00 charge added if your copay is not paid at time of visit to cover billing service charges.

CREDIT CARDS

Credit Cards are accepted for your convenience, but due to the high cost of this service, we will charge $1.00 per transaction. If you pay by cash or check there will be no additional charge

MISSED APPOINTMENTS/ NO SHOW POLICY

A missed appointment prevents our practice from providing care to other patients. Our office will make an attempt to remind you of your upcoming appointment if we have the time and staff available to do so but this is a courtesy and should not be expected.

There will be a $50.00 fee if you do not call to cancel your appointment twenty-four (24) hours in advance or if you do not show up for your routine follow up (15 minute) appointment.

There will be a $75.00 fee if you do not call to cancel your appointment twenty-four (24) hours in advance or if you do not show up for your physical/surgical clearance (30 minute) appointment.

You are responsible for these fees. They are not covered by your insurance carrier.

REFUNDS

When we determine that a refund is due, it will be refunded within 90 days of discovery. If you have an appointment scheduled and the credit balance is $70.00 or less, we will hold the credit balance until that visit.

FORM FEES

There will be a fee for all forms needing to be filled out by the office. Depending on how involved the form(s) is and how much time it takes to complete the form(s) the fee will be between $15.00 and $35.00. This will need to be paid by cash or check prior to the forms being released.

MEDICAL RECORDS

Medical records release requires a signed consent and a fee of $.75 per page as determined by NYS law. Payment will be due prior to the release of these records.

SCHEDULED APPOINTMENTS

We understand that delays can happen however we must try to keep other patient appointments on time. If you arrive 15 minutes past your scheduled appointment time we will try to accommodate you but reserve the right to reschedule your appointment.

**LABORATORY/PATHOLOGY TESTING**

We use **Quest Diagnostics and X-Cell Laboratories**  for all specimens obtained in our office. If your insurance requires a different laboratory to be used, you must inform us before the procedure. If not, your insurance may deny the claim for the laboratory/pathology specimen sent in. You will then be responsible for any out of pocket costs from the laboratory, pathologist, etc.

NOTICE OF PRIVACY PRACTICES

It is available to read in the office or a copy will be provided to you upon request. Rev. 01/01/2023