Bergen Internal Medicine

6 Horizon Road Lobby Level
Fort Lee, NJ 07024
(Tel) 201-886-8989 Fax (201) 886-8990
Website: bergeninternalmedicine.com

Financial Policy

Bergen Internal Medicine believes in a healthy communication with our patients. The following information is detailed to prevent any miscommunications regarding financial responsibilities for medical care. For your convenience, Bergen Internal Medicine accepts cash, checks, money orders and Visa/MasterCard (only if fee greater than $14).

At each visit:
We will verify your current address and phone number and update your insurance. Please BRING your insurance card!

Copayments MUST be paid at the time of your visit as per your insurance policy. If co-payment is not paid at the time of your visit, an assessed $10.00 fee will be added, regardless of the COPAY amount. We will file electronically your insurance claims for the insurance plans we participate in ONLY!! If you DO NOT have insurance, payment in full is required at the time of your visit.

If a service is provided which is not covered by your insurance company, you will be **responsible** for the payment at the time of the service. Not all insurance companies will pay for physical exams, vaccines, or procedures provided by the physician. PLEASE BE AWARE OF YOUR INSURANCE POLICIES!!!

If we have not received a payment from your insurance company within 30 (thirty) days after service, you will be responsible for the balance due.
All outstanding balances must be paid in full at the time of your visit.

Cancellation Policy or NO SHOW Policy:
*We require 24 hours notice to cancel your appointment. Failure to cancel an appointment will be subject to a $50 (fifty) dollar cancellation fee. Payment of this fee is required at or before the next scheduled office visit.

Check Policy:
*Any returned checks will be assessed a $50 dollar return check fee. Payment for service in addition to $50 return check fee is due within one week of the service to be paid in CASH or MONEY ORDER. No further checks will be accepted from the individual.
**Failure to remit payments for balances due in full within 60 days of the initial bill will result in the transfer of the billing statement to our collection agency and termination of physician-patient relationship.

Acknowledgement: I understand by signing I have read and agree to the above policy.

X _____ _____
Responsible party's signature **Date**

_____
Print Name

REV 9/13/2015

Bergen Internal Medicine
6 Horizon Road Lobby Level Fort Lee, NJ 07024
(Tel) 201-886-8989 Fax (201) 886-8990
Website: bergeninternalmedicine.com

Health Insurance Plans(s) Accepted

HORIZON BC/BS ADVANTAGE EPO (SILVER)

ADVANTAGE EPO (BRONZE)

ADVANCED EPO BASIC AND ESSENTIAL DIRECT ACCESS DIRECT 10 & 15

NJ DIRECT

NJ PLUS PPO (EXCEPT BLUE CMD)

CIGNA

EMPIRE BC/BS (NEW JERSEY/ NEW YORK)

MEDICARE (GOVERNMENT FUNDED ONLY)

OXFORD (FREEDOM & LIBERTY)

QUALCARE (HNH ONLY!!)

UNITED HEALTHCARE (EXCEPT THE EPO PLAN)

REV 9/10/2015