FINANCIAL POLICY

Welcome to the CareMount Medical, P.C..

Thank you for choosing our Practice. We are committed to the success of your medical treatment and care. Please understand that honoring your obligation to pay your bill is part of this ongoing relationship.

Listed below we have answered some of the most common financial questions. If you need additional information about any of our financial policies, please speak to a Patient Assistance Representative at 914-242-1388.

Self Pay

Please contact Patient Assistance at 914-242-1388 to establish a payment arrangement.

A deposit of $150.00 will be required from all Self Pay patients presenting for an office visit. This is only a deposit and you will be balance billed for any additional charges. This does not include Laboratory and Radiology fees.

Non-participating Insurance Plans

CareMount Medical does not have a signed agreement with very few Insurance Plans. However, in these instances, a deposit of $75.00 will be required from all patients presenting with a non-participating insurance plan.

This is only a deposit and you will be responsible for any portion not covered by your Insurance Plan. This could include your deductible and coinsurance amount. We will submit a claim to your insurance company as a courtesy to you.

Participating Plans

CareMount Medical contracts with many different insurance plans. Please refer to CareMountMedical.com for a full list of participating plans. You will be responsible for all co-pays, deductibles and coinsurance. If your plan requires a referral, it is your responsibility to obtain one prior to your scheduled visit.

Procedures

Some Specialists may use equipment or scopes to aid in making a diagnosis. These are separate charges not included in the office visit and the service may be subject to an in-network deductible.

Anesthesia services will be billed by a separate entity based on the procedures provided. Coverage restrictions may apply. Please contact Bedford Anesthesia at 914-242-2650 for anesthesia billing questions.

If your Physician recommends surgery, you will be contacted by a Surgical Coordinator. They will answer and discuss questions regarding our surgery scheduling process and your financial responsibility.

Cosmetic Services

Payment in full is expected for all Cosmetic procedures performed in the office, at the time of service.

Surgery and Dermatology Procedures

All Cosmetic procedures scheduled at the Hospital or Ambulatory Surgery Center must be paid in full 1 week prior to the scheduled surgical date, unless other arrangements have been made with the Financial Coordinator.

Non-Covered Services (Orthotics, Hearing Aides, Contact Lenses)

Contact lens and Hearing Aide Policy

Non covered medical supplies such as orthotics, hearing aides and contact lenses must be paid in full before the item is released from the office.

Obstetrical Payment Plan

CareMount Medical, P.C. offers a special financial plan for all Obstetrical patients that do not have Health insurance or a non-participating plan. This payment plan includes all routine office visits, the delivery and the post natal visit. All imaging and laboratory bills are a separate fee. (All Hospital and Anesthesia charges will be billed by a separate entity, and are not included in CareMount Medical’s fee).

If you have an Insurance Plan that we participate with, you will be responsible for any copays, deductibles and coinsurance.

Vaccines

You will be responsible for payment according to your individual insurance plan.

Cancellation Policy

In an effort to accommodate all of our patients and optimize appointment availability, it is the policy of CareMount Medical that all scheduled appointments require a 24 hour cancellation notice. Please be advised, in the event you are unable to keep your appointment and do not provide the proper cancellation notice a fee will be charged.

Returned Check or Credit Card Chargeback Policy

A $20.00 service fee will be charged for all returned checks.

A $20.00 service fee will be charged for all reversals of credit card payments.

Authorization

I have read and agreed to the above Financial Policy. I understand that charges not covered by my Insurance Company, as well as applicable copayments, deductibles and coinsurances are my responsibility. I authorize my Insurance benefits be paid to Mount Kisco Medical Group to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Printed Patient Name ______________________________

Date_________________________

Signature____

Date_________________________

Relationship to Patient______________________________

(If signed by a Personal Representative of the Patient)