Gramercy Pediatrics
67 Irving Place • 3rd Floor, South • New York, NY 10003
420 West 23rd St. • Suite AGF • New York, NY 10011

Office Policy on Insurances and Payments

As a courtesy to you; our office participates with several insurance carriers. Please familiarize yourself with your insurance's practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. copays), we are legally required to collect these and no exceptions will be made. You are required to pay your copay at the time of your visit.
2. If your insurance requires you to meet an annual deductible before your health care is covered, you will be billed for the services rendered if you have not met your deductible.
3. You will be asked to leave a credit card number at the time of check in. This information will be held securely until your insurances have paid their portion and notifies us of your share. At that time any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you. Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.
4. **After hours, prolonged telephone encounters (greater than 5 minutes) or those that lead to a pharmacy or hospital call will be billed as telemedicine visits as per ACA guidelines. This may result in an additional charge in the form of a copay or may be applied towards your deductible. Please contact your insurance company for more information.**
5. **If your child cannot make the scheduled appointment time, you must notify the office 24 hours prior to the scheduled appointment. If we are not notified 24 hours prior to the appointment, there will be a $75.00 cancellation fee per child/per non-routine appointment.**
6. **$150 cancellation/no-show fee for Well visits/Annuals**, if cancelled same day or less than 24 hours' notice.
7. **If your child cannot make the scheduled weight management appointment with Dr. Dyan Hes, you must notify the office 48 hours prior to the scheduled appointment. If we are not notified 48 hours prior to the appointment, there will be a $150.00 cancellation fee per child/per appointment**

I, _____ (print name) authorize Gramercy Pediatrics, LLC to charge outstanding balances/cancellation and no show fees to the following credit card:

	Account Number	Expiration Date	Security Code
American Express			
Master Card			
Visa			
Discover			

Email: _____

Name on Card: _____ **Signature:** _____