Harmony OB/GYN
34-36 Progress Street, Suite A6, Edison NJ 08820
PHONE: (908) 757-9555 FAX: (908) 757-2312

Office Practice and Billing Policies: Authorization for Payment:

You are responsible to inform this office of any change in your home address, phone number or/and medical insurance.
It is your responsibility to update self/spouse/parent Coordination of Benefit(COB) with insurances company, Failure to insurance update (COB) you will be responsible for unpaid(from INS) visits charges.

Our practice is committed to provide the best treatment for our patients and we charge what is customary for our area. You are responsible for any payment regardless of any insurance company's arbitrary determination of usual and customary rates for your insurance plan, you are responsible for the remaining balance.

YOU WILL RECEIVE A RECEIPT FOR ALL PAYMENTS MADE TO OUR OFFICE. THIS WILL BE YOUR ONLY RECEIPT AND PROOF OF PAYMENT. PLEASE RETAIN IT FOR YOUR RECORDS.

All patients with managed care plans without a co pay at the time of service will be billed the balance after we receive payment from your insurance company for your portion, if any. A service charge of $20.00 will be billed to your account if you fail to pay your portion, which is due no later than 30 days (1 month) following the insurance payment. Patients with pending balances will be billed 1.5% interest monthly. After three (3) attempts to receive payment, a final notice will be sent 20% added to the bill for a final balance. Failure to pay pending balance after final notice, in ten (10) days**, will result in forwarding your account to the collection agency. Also you will be responsible for collection agency's charges along with the amount you owe.**

I authorize payment of any medical benefits to Kirit Patel, M.D., P.A. for any services rendered. I understand that I am personally financially responsible for this account to Kirit Patel, M.D., P.A. for charges not covered by my insurance.

Authorization to release information: I authorize the release of any medical information necessary to process any claims. I understand that I am responsible for all charges, regardless of insurance coverage. I permit a copy of this authorization to be used in place of the original.

The pending balance following my insurance payment for the services, if I do not pay within 60 days or some other reasonable mutual agreement is not made, then I am responsible including collection agency charges that occur due to delay.

I have read and understood the above policies and I will follow.

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Patient’s Name & Date of Birth

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Patient's Signature & Today’s Date