Long Island Bone & Joint, L.L.P. Financial Arrangements and Insurance

Patient Name: _____ **Date of Birth**: _____

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding our payment policy.

FULL PAYMENT FOR OUR SERVICES IS DUE AT THE TIME SERVICES IS RENDERED, unless you are a member of an HMO/insurance plan that we participate in. We accept cash, checks, MasterCard, Visa, American Express, or Discover. We request that you provide us with complete insurance information at the time of your initial visit. For fracture care and/or surgical procedures we may accept assignment of insurance benefits. Currently we participate (accept assignment) in:

AARP
BlueCross BlueShield (Dr. Legouri only)
Cigna PPO
Island Group
Magnacare
Medicare
No Fault
Oxford Freedom
United Healthcare Choice Plus
Workers Compensation

"Accept Assignment" still requires you to pay the required co-payments, co-insurance and deductibles applicable to your particular insurance plan. Return checks are subject to a $20.00 fee. Account balances over 90 days past due, will incur an account management fee of $10.00. Account balances over 90 days past due may be reported to credit reporting agencies as delinquent. The guarantor will be responsible for all collection agency and legal fees associated with balances over 90 days past due. Co-payments not paid at the time pf the visit are subject to $15.00 surcharge.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance. We are not a party to that contract.
2. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage of "U.C.R." "U.C.R." is defined as usual, customary and reasonable fees for this region. Our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. All Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or Managed care **co-pays** must be paid at the time of each visit. Co-payments not paid at the time of the visit are subject to $15.00 surcharge.
5. If you belong to an HMO and you do not have a valid **referral** from your PCP on file or with you, you are required to pay in full for the services rendered at the time of service.

We must emphasize that as a medical care providers, our relationship is with you, not with the insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, call our billing department for help in managing your account. If you have any questions about the above information, PLEASE do no hesitate to ask. We are here to help!

If it is necessary to cancel your scheduled appointment we require 24 hours notice. If you fail to do so, you will incur a **$25.00 No Show/Late Cancellation Charge**.

The information given is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance for benefits which I am entitled. **I will not hold Long Island Bone & Joint, L.L.P. or any member of the staff responsible for any errors or omissions that I may have made in completion of this form.** I do hereby authorize the responsible insurance carrier(s) to make payment directly to Long Island Bone & Joint, L.L.P. I understand that I am financially responsible to Long Island Bone & Joint, L.L.P. for charges not paid by my insurance company. I authorize Long Island Bone & Joint, L.L.P. to release any information required to support all claims. I hereby authorize Dr. Fracchia; Dr. Legouri; Dr. McGinley; Dr. Savino; Dr. Hubbell; Dr. Marano; Dr. Yu and/or their associates or assistants to perform diagnostic and therapeutic measures on the above patient.

Print Name: _____ **Sign**: _____ **Relationship**: _____ **Date**: _____

Payments for today's services will be made by: CASH CHECK VISA MASTERCARD AMEX DISCOVER

Due to HIPAA Law we are not allowed to disclose any medical information without written authorization.

- Do we have permission to leave a message (with anything more than an appointment reminder) on your answering machine at home? **YES / NO**
- Do we have permission to leave a message at your place of employment? **YES / NO**
- Do we have permission to discuss your medical condition with any member of your household? **YES / NO**
  If yes, whom: _____ Relationship: _____
  This does not give authorization for anyone to receive your medical records or films. Patients must sign a records release for to receive copies of those records.

Print Name: _____ **Sign**: _____ **Relationship**: _____ **Date**: _____