**NYC-METRO PHYSICIAN SERVICES PC**

**FINANCIAL POLICIES AND PATIENT RESPONSIBILITY**

I understand that NYC-Metro Physician Services PC, my treating physicians and their respective designees, will use and disclose my health information for all purposes necessary for treatment, payment and health care operations, including but not limited to release of information requested by my insurance company (or carrier) and any information necessary for discharge planning purposes.

* **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to NYC-Metro Physician Services PC. I understand I am financially responsible for non-covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.
* **FINANCIAL LIABILITY:** I have been provided a copy of the NYC-Metro Physician Services PC financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to NYC-Metro Physician Services PC for care and treatment, including co-payments and deductibles as provided under my plan. Benefits, if any, paid by a third party, will be credited on account. I understand that I will be responsible for any charges if any of the following apply:
	+ My health plan requires prior referral by a Primary Care Physician (PCP) before receiving services at NYC-Metro Physician Services PC and I have not obtained such a referral or I receive services in excess of the referral, and/or
	+ My health plan determines that the services I receive at NYC-Metro Physician Services PC are not medically necessary and/or not covered by my Insurance plan, and/or
	+ My health plan coverage has lapsed or expired at the time I receive services at NYC-Metro Physician Services PC, and/or
	+ I have chosen not to use my health plan coverage, and/or
	+ The physician I see does not participate with my health care plan.
* **MEDICARE SIGNATURE ON FILE (Medicare Patients Only):** I request that payment of authorized Medicare benefits be made either to me or on my behalf to all providers who treat me or any services furnished to me by those providers. I authorize the holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits or benefits for related services.

 **Patient’s Medicare Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am at NYC-Metro Physician Services PC; such as, x-rays, imaging services, and laboratory tests. I understand that some physicians may not provide services in my presence, but are actively involved in the course of diagnosis and treatment. I hereby authorize payment directly for these services under the policy(s) or plan(s) issued to me by my insurance carrier. I understand that I may incur additional charges as a result of these ancillary services; I agree to pay all charges due with respect to such services to the extent the charge is due after credit is given for benefits paid on my behalf by any third party payor.
* **PRESCRIPTIONS:** I acknowledge that my treating physician may obtain a prescription history if necessary.

Preferred Pharmacy / Location: Phone #:

* **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that, based on the policy of individual physician offices, I may incur a cancelation fee if I do not provide the required notice of cancelation, or if I do not keep my appointment and have not canceled.

**Health Maintenance Organizations (HMO)** are those with co-pay per visit. All co-pays are collected at the time of the visit. In order to see you, we must be designated as your PCP with your HMO.

**Preferred Provider Plans or Choice Option Plans (PPP, PPO, POS)** are plans that allow you to choose your provider. There may be a deductible and/or co-pay collected at the time of the visit. If we are not on your preferred list or are outside the preferred panel the paid benefits may be at a lower percentage (for example 70% instead of 80%). You will be expected to pay the difference at the time of service.

**Indemnity plans** are those with deductibles, pay a percentage of the bill and allow you to choose your physician. You are responsible for the amount not covered by insurance.

**Medicare** If you have supplemental GAP coverage, secondary insurance, we will file claims for your services to both carriers. Deductibles, co-payments, and fees for any non-covered services are due at the time of service. All Medicare patients are required to sign a waiver indicating that they understand that they will be responsible for non-covered services denied by Medicare, GAP coverage, or their supplement insurance carrier.

**Patient Responsibility:**

* You are responsible for all charges resulting from treatment provided by NYC-Metro Physician Services, PC. We bill most insurance carriers. However, primary responsibility for the account is yours.
* Your co-payment is always due at the time of service; if co-pays are not paid at the time of service there is a $10.00 billing fee that will be added to your balance.
* Any remaining balance owed by you is due when you receive your first bill, unless other financial arrangements are made. If you have a delinquent balance, we may ask you to make a payment at the time of your next visit with us. Balances due by patients under $10.00 will not be sent a statement due to cost; these balances will be collected from the patient at the next office visit.

**Insurance Billing:**

* It is your responsibility, (or that of the financially responsible party), to provide current, accurate insurance billing information. As a courtesy, we will bill your insurance, however, you (or the financially responsible party) are responsible for any amounts that insurance does not pay. If your insurance information changes, please provide the new insurance information prior to receiving additional care. If your insurance coverage is not in effect at the time you receive care, or if your plan does not cover the services that you receive, you will be responsible to pay the charges.
* Medicare: We participate with Medicare. We will bill Medicare as your primary insurer. We will also bill your supplement insurance provider.
* Medicaid: We do not accept Medicaid. All Medicaid patients are required to sign a waiver indicating that they understand that they will be responsible for the non-covered services by Medicaid.

**Non-Insured Patient Payment:**

If you do not have insurance, we will provide your care on cash for services basis. A $100 deposit is due at the time of the visit for all private pay **new patient** visits. A $50 deposit is due at the time of the visit for all **established patient** visits. Patients will be billed for any remaining balance. Services do not include medications, blood draws, lab work, or administration of immunizations).

**Check Returned:**

It is our office policy to charge a **$20.00** fee for checks that are returned

**Delinquent Accounts:**

Accounts that become delinquent may be subject to collection activity, and a $20.00 late fee may be added to cover the cost of additional handling required.

**Authorization to Release Information:**

* In obtaining payment for services, I authorize my healthcare provider, NYC-Metro Physician Services, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representatives, and my employer or union if they are involved in processing the claim. For further information regarding disclosure of health information, please refer to the Notice of Privacy Information Practices.
* If I have been referred by, or am being referred to, another healthcare provider, I authorize NYC-Metro Physician Services to release my medical information to this provider for continuing care.
* I also assign NYC-Metro Physician Services all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges whether covered by insurance or not. I also understand that balances outstanding for more than 90 days may be subject to a processing fee.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure the payment of services.

I have been provided the NYC-Metro Physician Services PC Patient Financial Policies. I understand the information listed above which has been fully explained to me.

**Patient Signature Date**

**Guarantor Signature Date**