PARKER AT YOUR DOOR
PARKER JEWISH INSTITUTE

NYC –Metro Physician Services PC
Consent for Service

Patient's Name: _____

I hereby consent and authorize NYC –Metro Physician Services PC, its agents and associates to provide care and treatment to me in my home. This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at your home or any other satellite location. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

Authorization For Release of Information
I hereby consent and authorize NYC –Metro Physician Services PC to release and receive protected health information for the purposes of treatment and healthcare operations. The exchange of information may occur between, but is not limited to, physician, other healthcare providers and regulatory and/or accrediting reviewers.

Supplies
I understand that I will be informed of any DME (Durable Medical Equipment) that is recommended by the care team and that right to decide not to have the equipment ordered. I understand that this equipment may be paid for by my health plan (Medicare, Medicaid). I will be informed of any copays and/or charges I am liable for before equipment is ordered

Consent
This consent to Service is applicable to NYC –Metro Physician Services PC. I understand what I have read what was explained to me and agree to the agreement. Additionally, I understand that either party may terminate this agreement for any reason and/or any time.

_____
Signature of Patient or Representative Date

_____
Name of Patient or Representative Relationship to Patient

_____
Name of Witness

_____
Signature of Witness Date

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NYC-METRO PHYSICIAN SERVICES PC
FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

Please complete all sections.

Date: _____

Last Name: _____ First: _____ S.S#: _____

Address: _____ City:_____ State: _____ Zip: _____

Sex: _____ Age: _____ Date of Birth: _____ Marital Status: _____

Phone Numbers: Home: _____ Cell: _____ Work: _____

Email: _____ Pharmacy: _____ Phone: _____

Emergency contact (not living with you): Last: _____ First: _____

Relationship to Patient: _____ Phone: _____ Alt: _____

Address: _____

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.

Responsible party agrees to fill out new form when any of the above information changes. Wrong information may result in incorrect filing and subsequent charges.

PRIMARY INSURANCE:

Insurance Company:_____ Contact #: _____

Subscriber ID_____Name of Insured Card_____Signature_____

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Patient Name: _____ Date of Birth: _____

SECONDAY INSURANCE:

Insurance Company:_____ **Contact #:** _____

Subscriber ID_____**Name of Insured Card**_____**Signature**_____

TERTIARY INSURANCE:

Insurance Company:_____ **Contact #:** _____

Subscriber ID_____**Name of Insured Card**_____**Signature**_____

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.

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- 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.
- I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amounts, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment whenever required.
- I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider is not recognized by insurance company or plan, it may result in claims being denied or higher out of pocket expense to me. I understand this and agree to be financially responsible and make full payment.
- I understand and agree it is my responsibility to know if my PCP (primary care physician) choice had been processed by my insurance company or plan. If I have requested a PCP change that is not processed by my insurance company, it may result in claims being denied. I understand this and agree to be financially responsible and make full payment.
- I understand that any account balance that is 90 days past due will be sent to collections and that it is my responsibility to ensure that my insurance and contact information is always current and updated.

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.

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Patient Name: _____ Date of Birth: _____

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance for my visits. This includes any medical service or visit, preventive exam or physical, lab testing, x-ray, EKG, and any other screening service or diagnostic testing ordered by the physician or the physician's staff. I further agree to pay the balance of the charges not paid by my insurance. Any balance that is not paid within 45 days will also be my responsibility. I hereby authorize the release of any information necessary to secure payment of benefits. I also authorize the use of this signature on all insurance submissions. If the patient is a minor, I as a legal guardian give consent for treatment for this and future services rendered. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. 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**

Responsible Party Name: _____
(Please print name of Responsible Party if different from Patient)

_____ _____
Responsible Party Signature **Date**

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NYC –Metro Physician Services PC

I have received a copy of the

- Patient Rights
- Patient Responsibilities
- Advanced Directive
    - Including Health Care Proxy and Living Will
- Notice of Privacy Practices
- Summary of Financial Policies
- Consent for Treatment

_____

Print First and Last Name

_____

Signature of Client/Representative

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NYC-Metro Physician Services, PC

NOTICE OF AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS

Patient Name_____ _____ ____

Date of Birth_____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS:
I HEREBY AUTHORIZE DIRECT PAYMENT OF INSURANCE BENEFITS TO NYC-METRO PHYSICIAN SERVICES, PC or the physician individually for services rendered to my dependents, or me, by the physician or those under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit. I understand and agree that I will be responsible for any co-pay or balance due that NYC-METRO PHYSICIAN SERVICES, PC is unable to collect from my insurance carrier for whatever reason.

AUTHORIZATION TO RELEASE NON-PUBLIC INFORMATION:
I certify that I have read and been offered a copy of the NYC-METRO PHYSICIAN SERVICES, PC "Notice of Privacy Practices". I hereby authorize NYC-METRO PHYSICIAN SERVICES, PC and/or the physician individually to release any of my or my dependent's medical or incidental nonpublic personal information that may be necessary for medical evaluation, treatment, consultation, or the processing of insurance benefits.

MEDICARE / MEDICAID INSURANCE:
I certify that the information given by me in applying for payment under these programs is correct. I authorize the release of any of my or my dependent's records that these programs may request. I hereby direct that payment of my or my dependent's authorized benefits be made directly to NYC-METRO PHYSICIAN SERVICES, PC or the physician on my behalf.

LAB/X-RAY/DIAGNOSTIC SERVICES:
I understand that I may receive a separate bill if my medical care includes lab, x-ray, or other diagnostic services. I further understand that I am financially responsible for any co-pay or balances due for these services if they are not reimbursed by my insurance for whatever reason.

PRESCRIPTIONS:
I acknowledge that my treating physician may obtain a prescription history if necessary.

Preferred Pharmacy / Location:__ _ Phone #: _____ _____

CONSENT TO TREATMENT:
I hereby consent to evaluation, testing, and treatment as directed by my NYC-METRO PHYSICIAN SERVICES, PC physician or those under his/her supervision.

I have read and agree to all of the above information:

PATIENT SIGNATURE: __ _____DATE: _____

GUARANTOR SIGNATURE:_____DATE: _____
(If different from patient)

GUARANTOR NAME (Please Print):