



Financial Agreement / Receipt of HIPAA Privacy Notice / Consent for Treatment

We find that open communication with our patients regarding our financial policy assists us in providing the best possible service to you. Please take the time to read these policies concerning medical insurance benefits. If you have questions, please feel free to ask. If you are having an office based endoscopic procedure, the policies below also apply to anesthesiologists contracted by Long Island Digestive Disease Consultants (LIDDC).

Medical insurance is intended to only be an aid and rarely covers 100% of the total cost of your medical care. Every plan has its own provisions, which we must abide by. Certain costs will be passed along to the patient, such as deductibles, co-payments and co-insurance amounts. As a patient, you have certain responsibilities: (1) to pay amounts not covered by your insurance carrier (2) to be knowledgeable about your plan's covered and non-covered services (3) to notify the registrar if there are any changes in your coverage. We will do our best to work within your plan to help you receive maximum benefits. Please be advised that responsibility for full payment is solely yours, whether or not you have insurance. If it becomes necessary to send your account to a collection agency or attorney, you will be responsible for all costs, interest, and attorney fees. There is a \$25 fee for all checks returned for insufficient funds. LIDDC reserves the right for all future payments by the undersigned to be paid in cash or money order. For all patient balances over 30 days, there is a \$5.00 statement processing fee, cumulative per month, on unpaid monies due to the practice. LIDDC reserves the right to charge a no-show/cancellation fee for any office related visits and procedures.

Managed Care Plans: We participate with a full range of insurance plans in order to offer flexibility to our patients. Our medical providers strictly follow the regulations and guidelines of these plans. On the date of service, we are contractually obligated to collect any appropriate co-payments, co-insurance and deductibles from you, the patient, as per our agreement with the carriers.

Medicare: We participate with Medicare, and closely follow their billing guidelines. You will be responsible for your \$100 deductible, or any unmet portion thereof, at the time of service. We will also collect the 20% co-insurance portion of Medicare's approved charges for covered medical services upon being informed of them by Medicare. If you have supplemental coverage, we will automatically submit your co-insurance to that insurance company. Since your Medicare supplemental insurance will not cover certain specified medical services, it is your responsibility to pay the fees for these non-covered services when we inform you about them, and ask you to sign an Advance Beneficiary Notice as required by Medicare.

All Other Insurance: Due to the complexities of insurance billing, it is necessary for us to collect the appropriate percentage payment or deductible due at the time of service as directed by your insurance company. We will then submit the claim to the insurance carrier, who will then reimburse Long Island Digestive Disease Consultants, P.C. for their portion of the covered services. If the carrier sends a reimbursement check to you, it is your responsibility to sign it over to Long Island Digestive Disease Consultants, P.C. immediately. Failure to do so will lead to sending your account to a collection agency or attorney.

Secondary Insurance: Patients who are covered by more than one medical insurance carrier should notify the receptionist at the time of registration. It is your responsibility to know the limitations of your supplemental/secondary policy. If you have two insurance policies, the co-payment of the primary insurance is collected at the time of service.

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION:

As the provider of healthcare services, we are hereby authorized to release any medical information required in treating you, for payment for services rendered to you or for other healthcare operations of LIDDC, or the healthcare operations of an LIDDC contracted anesthesiologist, if applicable. Before we release information to parties other than for treatment, payment of your account or for healthcare operations, we will require a specific authorization from you. By signing below, you acknowledge that you have received LIDDC's HIPAA Privacy Notice and understand that this notice also serves as a Notice of Privacy Practices of contracted anesthesiologists utilized in the course of an office-based procedure. You have a right to restrict uses and disclosures of your health information as it pertains to treatment, payment and healthcare operations. If your restrictions are accepted, these restrictions will be binding. You also understand that LIDDC or any

CONSENT FOR THE RELEASE OF MEDICAL INFORMATION: (CON'T.)

contracted anesthesiologist is not required to agree to your requested restrictions. By initialing below, you do not request any restrictions for uses and disclosures of your health information for treatment, payment or healthcare operations at this time. _____(INITIAL). You understand that you have a right to revoke this consent at any time in writing, but if you do, your revocation will not have an effect of any actions we have already taken in reliance of this consent.

CONSENT FOR MEDICAL TREATMENT:

I, the undersigned, am knowingly requesting medical services from LIDDC and, if undergoing an office based endoscopic procedure, an LIDDC contracted anesthesiologist. I am requesting these services willingly and voluntarily. I execute the same as my free and voluntary act for the purpose of receiving the healthcare services. By my signature below, I warrant that I am eighteen (18) years of age or older, of sound mind, and not constrained nor under any undue influence. I understand that my physician will be responsible for providing me with an explanation of current information regarding my diagnosis, treatment and prognosis and will require my consent on any procedures performed on me. My physician will ensure that I am adequately informed and that I understand the indications of any procedure performed by an LIDDC physician. I understand that I have the right to refuse such care, except in an emergency.

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY NOTICE:

I, the undersigned, acknowledge that I have been provided a copy of the LIDDC's HIPAA Privacy Notice and my signature below attests to this receipt.

ACKNOWLEDGEMENT AS SIGNER ON THE ACCOUNT:

Upon my signature below, I attest that I have read and understand all the provisions discussed herein. Any questions I have asked have been answered to my satisfaction and to the extent where I can place my signature on this document. I understand my rights and obligations as a patient of LIDDC. Should the patient be a legal minor as defined in the State of NY Statute, I hereby attest as the signer below, that I am the lawful guardian of the minor.

All Patients Must Read and Sign the Following Before Treatment Can Commence

ASSIGNMENT AND AUTHORIZATION

I authorize that my insurance benefits be paid directly to Long Island Digestive Disease Consultants, P.C. I acknowledge that I am responsible for full payment of services rendered. I have read the above information carefully, and agree with all of the terms.

I also authorize the release of any information necessary or helpful in processing the claim for reimbursement for medical services. This authorization is valid for the release of medical information to all insurance carriers.

As the signer below, I attest that LIDDC or any contracted anesthesiologist has the right to maintain my signature on file for the purposes of filing claims. Additionally, my signature below will act as authorization for today's and future treatments, unless I rescind such authorization in writing.

Printed Name of Patient/Guarantor on the Account

Signature of Patient/Guarantor on the Account

Date

Relationship if Other than Parent

Date

I authorize the staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

___yes ___no Home Telephone _____
___yes ___no Home Answering Machine _____
___yes ___no Cell phone and Voice Mail _____
___yes ___no Work phone and Voice Mail _____

Please list names of authorized people we may leave messages with:

Name/Relationship _____

Name/Relationship _____