Edward M. Stroh, M.D., P.C./Retina Consultants of Long Island

165 North Village Avenue, Suite 203, Rockville Centre, NY 11570 - Tel: 516-536-9525 WWW.EDWARDSTROHMD.COM

PATIENT'S NAME: **DOB** **DATE**

General Patient / Physician Agreement / Financial Policies

OUR FINANCIAL POLICIES

Your clear understanding of our Financial Policies is important to our relationship. Please ask if you have any questions about our fees, financial policy or your responsibility.

- **PARTICIPATION:** We do participate with many insurance plans; please confirm that our office accepts your insurance and/or Specific Plan as you may be responsible for any out of network fees, co-pays, or deductibles..
- **REMITTANCE:** If your insurance plan pays you directly, you agree to forward payment immediately.
- **COPAYS:**
- Payment for our services are due at time of visit; if your insurance plan requires copayment both the patient and physician are legally required to abide by this requirement.
- You will incur a **$20** service charge for copayments not paid at the time of service.
- If a check is returned for insufficient funds or stop payment, you will incur a **$35** surcharge fee
- A credit card processing fee or paperwork fee applies to all credit card transactions.

MISSED APPOINTMENT FEE

- A fee of **$40** will be incurred for all no show appointments without calling our office at least 1 hour in advance.

COINSURANCE/DEDUCTIBLES:

- Payment is expected promptly once your insurance plan informs our office that these expenses are patient responsibility, either in advance or after your visit.
- You will receive a statement from our billing offices that will outline your insurance company's payments as well as patient responsibility.
- **It is your responsibility to notify our office of any change in Primary, Secondary, or Tertiary insurance in advance or at the time of your visit.** Failure to do so may result in denied claims and you would be responsible.

You will receive a statement from our billing offices that will outline your insurance company's payments as well as patient responsibility.

MEDICARE PATIENTS:

- You are responsible for your yearly deductible and the 20% portion not paid by Medicare if you do not have secondary insurance
- If you have supplemental coverage, as a courtesy we will submit the claims for you.
- If you are enrolled in a Medicare HMO plan (such as Oxford, Aetna, United Healthcare, HIP, etc.), or if your Medicare HMO plan has changed, it is your responsibility to inform our staff before your visit.
- If the appropriate referrals are not obtained, you will be responsible for full payment of fees.

SELF PAY PATIENTS:

- Payment in full is expected at time of service.

NO FAULT/WORKERS COMPENSATION PATIENTS

- If the reason for your visit is due to a work related injury or because of an auto accident, you must inform the front desk so that you can discuss your situation with our billing staff. Failure to do so and providing us with all necessary information could lead to denied claims and you would be financially responsible.

AFFORDABLE CARE PLANS/HEALTHCARE EXCHANGES

- You are responsible for paying your Healthcare premiums in a timely manner. Failure to pay your insurance premiums will result in your benefits being terminated. If your insurance is cancelled for failure to pay your premium, or any other reason, you will be held liable for the amount of the bill. This amount will be due in full upon notice.

REFERRALS AND AUTHORIZATIONS: REFERRALS AND AUTHORIZATIONS:

- If your plan requires authorization from a primary care physician, it is your responsibility to obtain the written referral or authorization number prior to your visit with the doctor.
- YOUR APPOINTMENT WILL BE RESCHEDULED IF PROPER AUTHORIZATION HAS NOT BEEN OBTAINED

Surgery/Drug Treatment Policy

You agree to be responsible for any out of pocket expenses (ex. copayment, deductible, coinsurance) required by your insurance plan

- **IMPORTANT:**

•Any changes in your insurance company, plan, or deductibles must be stated at the time of visit, and you must bring any new insurance cards to the office and present them to our staff upon arrival. Failure to do so would leave you responsible for unpaid charges.

•If I have switched or Have a managed care plan that requires a referral, I understand that I am responsible to have a valid referral with me when I arrive for my appointment(s) without exceptions. If I have not told the doctor's office I may not be covered and I agree that I will bear the full financial responsibility.

The ever increasing time and cost burden required to complete the multitude of forms requires the start of the following charge policy.

- **Completion of one (1) form page = $20**
- **Completion of two (2) or more form pages = $40 (maximum charge)**

By signing below, you are acknowledging that you have read and fully understand our Office Policies

Patient/Responsible Party Signature:_____ Date:_____

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PATIENT'S NAME: DOB DATE

Please read the following paragraphs, initial that you have read, understand, and agree to the same.

CONFIDENTIALITY AND CONSENT TO RELEASE INFORMATION:

In an effort to provide the most efficient and effective healthcare, your treating physician will diagnose your illness according to your complaints, symptoms, test results, and medical history. In order to treat the patient appropriately, the patient understands and authorizes treating physician and/or facility to obtain any and all medical records relating to the patient and to communicate with previous physicians by any method, and/or any physician that can assist with the care of the patient, as long as confidentiality is kept at the physician level. I have read, understand, and agree with the above. I permit you to release any medical information to the physicians involved in my care. I consent to the practice of calling my home or other designated location and leaving a message on voice mail or in person in reference to an appointment reminder or any insurance item or bill. In addition, the practice may mail to my home appointment reminders or patients statements. **Initials: _____**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:

As provisioned by the Health Insurance Portability and Accountability Act of 1996 we must provide you with a detailed notice in writing of our privacy practices. By signing this notice you have acknowledged receipt of our Notice of Privacy Practices. I have been offered to read/receive a copy of **Edward M. Stroh MD PC/Retina Consultants of Long Island** **Initials: _____**

RELEASE FOR INSURANCE PURPOSES:

I authorize Edward M. Stroh MD PC/Retina Consultants of Long Island to release medical information for insurance purposes. I authorize payment to be made directly to Edward M. Stroh MD PC/Retina Consultants of Long Island if an assignment is indicated by my insurance company. As a courtesy, Edward M. Stroh MD PC/Retina Consultants of Long Island will contact insurance companies for authorization for services required. Edward M. Stroh MD PC/Retina Consultants of Long Island is not responsible for lapses of insurance or for incorrect information.

FINANCIAL POLICY:

I authorize **Edward M. Stroh MD PC/Retina Consultants of Long Island** to bill my insurance company for services rendered. I realize that I will be responsible for co-payments and deductibles at the time of services. Any portion not covered by insurance will be billed to me. If I am uninsured, payment is expected at the time of service. Late charges of 6% will be assessed against the outstanding balance for any amount owed over 60 days. If it becomes necessary to collect any balance due through an attorney, then the patient (and/or spouse/guarantor) agrees to pay all reasonable costs of collection, including attorney's fees, whether suit is filed or not.

I authorize **Edward M. Stroh MD PC/Retina Consultants of Long Island** to release medical information for insurance purposes. I authorize payment to be made directly to **Edward M. Stroh MD PC/Retina Consultants of Long Island** if an assignment is indicated by my insurance company. As a courtesy, **Edward M. Stroh MD PC/Retina Consultants of Long Island** will contact insurance companies for authorization for services required. **Edward M. Stroh MD PC/Retina Consultants of Long Island** is not responsible for lapses of insurance or for incorrect information. **Initials: _____**

FAILURE TO FOLLOW PHYSICIAN ORDERS:

"Physician Orders" are meant to improve and/or resolve the patient's medical condition and/or symptoms. The patient is expected to follow orders given. In the event the patient does not follow orders given, the patient may be discharged from the treating physician care and/or facility, thus releasing treating physician and/or facility from any injury or illness claim resulting from the patient's failure to follow orders. Not following orders given can included but is not limited to missing, postponing or refusal of additional tests to rule out, confirm or discover illness or failure to attend follow-up appointments. I have read, understand, and agree with the above. **Initials: _____**

HIPPA CONTACTS:

I designate the following representative(s) who the provider can communicate with on my behalf (example, spouse, son, daughter, friend, etc) If you do not designate anyone, the doctor will be unable to speak to anyone in your family regarding your medical condition or appointments.

Name: _____Relationship_____ Tel: _____

Name: _____Relationship_____Tel:_____

By signing below, you are acknowledging that you have read and fully understand our Office Policies

Patient/Responsible Party Signature:_____ Date:_____