FINANCIAL POLICIES AND PATIENT RESPONSIBILITY

1. **RELEASE OF INFORMATION:** I authorize my treating physicians and their respective designees, to use and disclose my health information for all purposes necessary for treatment (such as information necessary for your PCP, referring doctor, or others on your treatment team), 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.
   e **Initials**

2. **ASSIGNMENT OF INSURANCE:** I hereby authorize my insurance benefits to be paid directly to New York Epilepsy & Neurology. 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. _____ **Initials**

3. **FINANCIAL LIABILITY:** I have been provided a copy of the NY Epilepsy & Neurology financial policies and agree to the specified terms. I hereby agree to pay all charges due (or to become due) to New York Epilepsy and Neurology, PLLC 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 authorization or referral by a Primary Care Physician (PCP) before receiving services at NY Epilepsy & Neurology and I have not obtained such an authorization or referral or I receive services in excess of such authorization or referral, and/or
   - My health plan determines that the services I receive at NY Epilepsy & Neurology 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 NY Epilepsy & Neurology, and/or
   - I have chosen not to use my health plan coverage. _____ **Initials**

4. **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 during my hospital stay 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** _____

5. **ANCILLARY SERVICES:** I understand I may receive certain ancillary medical services while I am a patient of New York Epilepsy and Neurology; such as, anesthesia, interpretation of cardiac tests, interpretation of EEG tests, neuropsychological testing, imaging services (e.g., x-rays, MRIs) and pathology specimen examination. 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.
   _____ **Initials**

6. **CANCELED OR NO-SHOW APPOINTMENTS:** I understand that I may incur a cancelation fee if I do not provide 24 hour notice of cancellation, or if I do not keep my appointment and have not canceled. _____ **Initials**

I have been provided the New York Epilepsy and Neurology, PLLC Financial Polices. I understand the information listed above which has been fully explained to me.

_____ _____
Patient Signature **Date**

_____ _____
Guarantor Signature **Date**

Form Revised: 07/26/2010