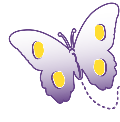


Advanced Parathyroid Surgery of New York

LEADERS IN MINIMALLY INVASIVE PARATHYROID SURGERY

Patient Name: ______________________________

Address: ______________________________

City: ______________ State: ________ Zip Code: ________

Phone Number: ______________________________

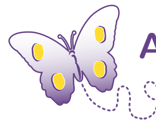
Assignment of Benefits Attestation and Privacy Policy Attestation

I hereby authorize my insurance company, including Medicare if I am a Medicare Beneficiary,to make payments to Advanced Parathyroid Surgery of New York for medical or surgical services or items rendered to me or my dependent by Advanced Parathyroid Surgery of New York payment, I understand that I am financially responsible for the charges. I authorize Advanced Parathyroid Surgery of New York to release any and all of my records to my insurer, or any other third party payer, legally responsible for the payment of medical expenses. I certify that the information provided or to be provided by me is correct and complete to the best of my knowledge. It is my responsibility to update any and all personal,insurance and health information.

Signature of Patient or Guardian: ______________________ Date: ______________

I acknowledge having read the privacy policy
(www.advancedparathyroid.com/practice-privacy-policy/)
of Advanced Parathyroid Surgery of New York

Signature of Patient or Guardian: ______________________ Date: ______________



Leaders in minimally invasive Parathyroid Surgery

FINANCIAL POLICY

Dear Patient:

1. It is our office policy that all co-pays, co-insurance and deductible charges be paid prior to services being rendered. In the event that you are scheduled for a surgery, payment is due no later than 24 hours before you are scheduled to report to the hospital or office.
2. All past due balances are expected to be paid before further services are rendered. If you have financial difficulty and cannot pay your past due balance, payment arrangements may be made by credit card, which will be kept on file and charged at intervals agreed upon by the billing department and the patient or guarantor.
3. If we do not accept your insurance as in-network, you will be responsible for the full cost of the service rendered. We will bill your insurance company for you and will issue you a refund if we receive payment. In the instance that your insurance should fail to pay for your visit, you agree to remain the responsible party and your payment will not be refunded.
4. **ALL REFERRALS ARE THE RESPONSIBILITY OF THE PATIENT & MUST BE PRESENTED AT THE TIME OF VISIT**. In the event that you fail to get a referral and one is required, you will be asked to sign a waiver and pay in-full or you may reschedule your appointment.
5. I understand that knowing the terms, limitations and guidelines of my health insurance policy is my responsibility as a patient and I assume all financial responsibility for any charges incurred as a result of policy termination or coordination of benefits or limitation otherwise not mentioned that results in non-payment.

Thank you for your cooperation. We look forward to serving you.

I, the undersigned, acknowledge, understand and agree to the contents of this notice.

PRINT NAME: ____

SIGNATURE: ______________________________ DATE: ________________

2004 Route 17M • Goshen NY 10924 • Phone: 1-888-760-0966 • Fax: 845-531-4829

www.advancedparathyroid.com