Consent and Disclosures Form

Long Island Gastro

The following two pages outlines our billing policies, authorization for treatment, assignment of benefits, release of medical information, and our privacy policies to comply with the Health Insurance Portability and Accountability Act (HIPPA).

Billing

- I (patient, parent, or legal guardian) understand that if the current insurance information is not received at the time of service, I will be responsible for full payments at the time of services are rendered.
- If I am a self-pay patient, I am financially responsible for all services received and that payment is expected at time service is rendered.
- In the situation of third part financial responsibility to cover the cost of your visit, the primary and ultimate responsibility for payment rests with you (patient, parent, or legal guardian).
- We are contracted with a number of managed care plans (Preferred Provider Organizations, Health Maintenance Organizations, and Independent Physician Associations). We must follow the terms of these plans including their financial relationships and mandatory co-payments and deductibles, which are required at time service is rendered.
- In regards to federal programs (Medicare and New York Medicaid), we have agreed to accept as full payment the government's discounted payment schedule. You are responsible for any mandatory co-payments and deductibles at the time of service (although you may have supplemental co-insurance which may cover the co-payment).
- I (patient, parent, or legal guardian) understand that it is my responsibility of bringing in a valid referral at the time of services rendered. If not, I will be fully responsible for the services rendered.
- This office confirms appointments as a courtesy; it is your responsibility to keep your appointment. If you are not able to keep your schedule appointment, please give us 24 hours notice. Missed Appointment Charge/NO SHOW CHARGE $25.00. There will be a charge of $100.00 for any scheduled procedure appointment that is not canceled within 24 hours or is a no show.

Authorization for Treatment

I hereby voluntarily consent to medical care for the above names patient encompassing diagnostic procedures and medical treatment by the physician, his/her assistants, or designees as may be necessary in his/her judgment. I acknowledge that no guarantees have been made as to the results of treatments or examination.

Assignment of Benefits

I hereby assign to Long Island Gastro all rights, title, and interests in the benefits payable to me by an insurance policy(ies)or benefits plan under which I am covered for services rendered by the physician. I understand that I am responsible for all charges not covered by the assignment along with any deductibles and/or co-insurance and hereby promise to pay any remaining balance.

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Signature of Patient/Parent/Legal Guardian Date