Adolescent-Young Adult Medicine of Great Neck, LLC

29 Barstow Road, Suite# 201, Great Neck, NY 11021 Tel. 516482-5400 Fax 516-482-5401

PATIENT REGISTRATION: ☐ **Primary Care** ☐ **Dermatology**

Last Name _____ First Name _____ M.I. _____ Age _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Work Phone _____ Date of Birth _____

Email Address _____ Gender _____ Marital Status _____ Preferred Language _____

Primary Physician _____ Telephone _____

Pharmacy Name _____ Telephone _____

What is your race? (Mark ALL that apply)
White
Black or African American
Asian
Native Hawaiian or other Pacific Islander
Other
Decline to Answer

Are of Hispanic or Latino origin or decent?
Yes, Hispanic or Latino
No, not Hispanic or Latino

Emergency Contact Name _____ Relationship to Patient _____

Emergency Contact Telephone _____

Parent's Name _____ Relationship to Pateint _____

Cell Phone _____ Work Phone _____

Parent's Name _____ Relationship to Patient _____

Cell Phone _____ Work Phone _____

☐ **SELF** **GUARANTOR/POLICY HOLDER/PERSON FINANCIALLY RESPONSIBLE**

Last Name _____ First Name _____ M.I. _____ Guarantor Date of Birth _____

Address _____ Relationship to Patient _____ Guarantor Tel. Number _____

GUARANTOR'S EMPLOYER INFORMATION

Employer _____ Employer Telephone Number _____

Employer Address _____

Authorized Person's Signature (Patient or Parent/Legal Guardian if Patient under 18)

* I authorize the release of any medical or other information necessary to process all claims.
* I authorize payment of medical benefits to Jonathan D. K. Trager, M.D. for services rendered.
* **I understand that I am personally responsible for, and agree to pay to this office, all co-pays, co-insurances, and deductibles as determined by my health insurance plan. I also acknowledge receipt of this office's "Financial Policy for Our Patients."**

X _____ _____

Authorized Signature: Patient or Parent/Legal Guardian if Patient Under Age 18 **Date**

_____ _____

Print Name **Relationship to Patient**

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Adolescent-Young Adult Medicine of Great Neck, LLC** to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations.

Adolescent-Young Adult Medicine of Great Neck, LLC's Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Adolescent-Young Adult Medicine of Great Neck, LLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices is available on this website, in our office, and may be obtained by forwarding a written request to the **Adolescent-Young Adult Medicine of Great Neck, LLC** Privacy Officer, Jonathan D.K. Trager, M.D., at 29 Barstow Road, Suite 201, Great Neck, NY 11021.

With this consent, **Adolescent-Young Adult Medicine of Great Neck, LLC** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, **Adolescent-Young Adult Medicine of Great Neck, LLC** may mail to my home or other alternative location any items that assist the practice in carrying out treatment, payment and

healthcare operations, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that **Adolescent-Young Adult Medicine of Great Neck, LLC** restrict how it uses or discloses my PHI to carry out treatment, payment and healthcare operations.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Adolescent-Young Adult Medicine of Great Neck, LLC's** use and disclosure of my PHI to carry out treatment, payment and healthcare operations.

I may revoke my consent in writing except, to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____ _____

Patient's Name Date

_____

Signature of Patient (Parent or Legal Guardian if Patient Under Age 18)

_____

Print Name of Parent or Legal Guardian if Patient Under Age 18

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Jonathan D.K. Trager, M.D.

Financial Policy for Our Patients

Welcome to our practice! We are providing you with a copy of our office's "Financial Policy for Our Patients" to help you understand your financial responsibility for our services. **Please read this carefully and retain this copy for your records.**

Understanding your financial responsibility for our services is especially important as patients are becoming more and more responsible for health care costs in the form of higher co-pays, co-insurances, and deductibles. **If you use health insurance in this office you are obligated to abide by the rules of your health insurance plan.**

Minor Patients: A parent or custodial guardian must accompany a minor and is responsible for payment of services. Unaccompanied minors without an emergency will not be seen and the appointment will have to be re-scheduled.

Divorced/Separated Parents of Minor Patients: The parent that consents to the visit/treatment of a minor is responsible for payment of services rendered. Adolescent-Young Adult Medicine of Great Neck, LLC will not be involved with separation or divorce disputes.

PATIENTS WHO NO-SHOW FOR AN APPOINTMENT WILL AUTOMATICALLY BE BILLED A NON-REFUNDABLE NO SHOW FEE OF $50.

For patients using health insurance plans which we accept:

If we are a participating provider with your insurance plan, we will submit the claim to your insurance company. To do this we must have complete and accurate insurance information and a copy of your insurance card. We also ask for a copy of your photo ID to help prevent identity fraud. *If you fail to notify us of an insurance change, you may be responsible for the entire bill as there is a statute of limitations for filing an insurance claim.*

Before receiving any of our services you may personally contact your health insurance company to inquire if you are responsible for any co-insurance or have a deductible to meet. Once we have provided you with a service, you are responsible for all co-insurances and deductibles. It is your responsibility to know if your health insurance is in effect on the day of service. If for any reason your health insurance is not in effect on the day of service, you will be responsible for all charges.

Co-Pays and unpaid balances are due at the time of visit. Please be prepared to pay all co-pays and unpaid balances. We do not bill for co-pays. We are not permitted to waive or reduce co-pays. Your visit may be re-scheduled if you are not prepared to pay the co-payment and all unpaid balances.

Co-insurance and Deductibles: If your health insurance company determines that you are responsible for any additional payments to us (such as a co-insurance or deductible), you are responsible for that amount.

Credit / Debit Card on File: We require a credit or debit card on file with our office if we will be billing your insurance. You will be asked for a credit card at the time you check in and the information will be held on a secure gateway that is completely compliant as required by law. When your portion of the bill is determined (following a review of your co-pay, co-insurance, and deductible) we will charge your credit card and mail you a receipt.

Referrals: If your health insurance company requires a referral to receive our services it is your responsibility to obtain one from your Primary Physician. **Referrals cannot be obtained after the visit and "backdated."** If you do not have a referral *at the time of service*, you can:

- still be seen without a referral [we do not turn patients away] and receive services; if you choose to do this, however, you are operating outside of the rules of your health insurance company in which case we cannot send a claim to your health insurance company; you will thus be personally responsible for all charges *on the day of service*
- re-schedule your appointment for when your referral is placed.

For patients with health insurance plans which we DO NOT accept or without health insurance:
Payment in full is required at the time of service. We will discuss with you the fees for our services before services are provided.

For lab tests (such as blood tests, urine tests, strep tests, influenza tests, cultures, PAP tests, skin biopsies, etc.):
It is our policy to order, perform, and send only medically necessary tests. We will send your specimen(s) to a laboratory which is in your health insurance plan's network (if you have health insurance). Certain lab tests are done in our in-office CLIA (Clinical Laboratory Improvement Amendments)-certified laboratory (rapid strep test, rapid influenza test, urinalysis, urine pregnancy test, blood sugar).

- **Even with in-network laboratories, or with our in-office CLIA-certified laboratory, various tests may only be partially covered or not covered at all by your health insurance plan; this may result in a separate bill from the laboratory (or from us for tests which we perform) for which you are personally responsible.**
- **It is not possible for us to determine in advance if your lab tests will result in a bill from the laboratory or not or if you will be responsible for payment for any in-office tests.**
- **Before having any lab tests done you may personally contact your health insurance company to inquire if you are responsible for any coinsurance or any payment for any lab tests or have a laboratory deductible to meet.**
- **OUR OFFICE ASSUMES NO FINANCIAL RESPONSIBILITY FOR LAB TEST FEES THAT ARE BILLED TO YOU BY THE IN-NETWORK LABORATORY TO WHICH YOUR TESTS ARE SENT.**
- **For those patients without health insurance you will be personally responsible for all lab charges.**

DELINQUENT ACCOUNTS WILL BE REFERRED FOR COLLECTION AT THE DISCRETION OF THE OFFICE MANAGER.

Accepted forms of payment: We accept cash, checks and credit cards (AMEX, MasterCard, Visa and Discover). There is a $20 service charge for any check returned for insufficient funds.

HAVE A WONDERFUL DAY!

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Credit Card Policy

Our practice will no longer be sending patient statements so you will no longer receive bills from us in the mail. We now require a credit card on file with our office if we will be billing insurance for you. If you do not have insurance, then payment is due at the time of service.

As you know if you have ever checked into a hotel or rented a car the first thing you are asked for is a credit card which is swiped and later used to pay your bill. This is an advantage for both you and the hotel or rental company since it makes checkout easier, faster and more efficient.

You will be asked for a credit card at the time you check in and the information will be held in a secure gateway system. When your portion of the bill is determined (following a review of your copay, co-insurance, and deductible) we will charge your card and a copy of the receipt will be mailed to you. Please note that your card will not be charged until you have a charge due and no funds are held. This simply allows your card to be charged when a bill is due. You can cancel this agreement at any time.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment. If you have any questions about this payment method, do not hesitate to ask.

Frequently Asked Questions:

Why the change?
Many changes are occurring in healthcare including increased patient responsibility and deductibles. In order to continue providing care and to keep medical costs as low as possible we need to ensure that we have a guarantee of payment on file in our office. You will find that over time, most medical practices will require full payment up front or a credit/debit card on file for payment of patient balances.

But I always pay my bills, why me?
We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. But with the healthcare changes that are occurring, it is now cost-prohibitive to send out bills to collect balances.

How will I know how much you are going to charge me?
You will receive a letter in the mail from your Insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits (EOB). This letter tells you exactly, according to your health insurance coverage, how much of your health care bill is your responsibility and how much is the responsibility of your insurance plan.

Then what?
We receive the same letter that you do. It arrives about 10-30 days after your appointment. We look at each EOB carefully and determine what your insurance has determined as patient responsibility. This is the same way we normally determine how much to bill you in the mail.

But wait, I'm nervous about leaving you my credit card.
We do not store your sensitive credit card information in our office. It is stored on a secure gateway that is completely compliant as required by law-just like a hotel or rental car agency. We access your information on this site only to process a payment and we do not have access to your credit card number. If you absolutely do not want your credit card on file, then you can choose to pay the entire billed amount at the time of service. If your insurance then pays, we will send you a refund.

What if I need to dispute my bill?
We will always work with you to understand if there has been a mistake, and we will work with you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the letter they send to us, in the same way that we normally determine how much to bill you in the mail.

What if I don't have a credit card?
If you do not have a credit card, you can pay 100% for all services in cash at the time of service. If your insurance then pays, we will send you a refund.

How can I see my bill?
You can look at your EOB from your insurance company or call your insurance company.

In you have questions about our office policy or difficulty meeting your financial obligations, please speak with our office manager, Karen Trager, at 516-482-5400.

I have read and understand the above information regarding having a credit card on file:
Patient Name:_____ Date:_____

Signature:_____
Name of Parent or Legal Guardian if patient is under 18: _____

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No-Show and Late Appointment Policy

We have developed this no-show and late appointment policy to best meet the needs of our patients. We welcome your feedback and suggestions and will make updates to this policy as needed.

At our office we pride ourselves on keeping your appointment schedule on time. One of the ways we do this is by giving each patient ample time to meet with the doctor.

At a busy medical practice like ours it is often impossible to predict what a day will bring. A sudden emergency may throw us off our well-planned schedule. (Remember, the emergency may someday be yours and you would want us to spend as much time with you as is necessary). On the rare occasion we have to cancel an appointment, we will call and explain and reschedule as soon as possible.

Unpredictable traffic jams or life emergencies may cause our patients to be late or miss an appointment altogether. We understand that sometimes being late is unavoidable and usually a quick phone call to the office explaining your tardiness or last-minute cancellation is sufficient.

Late Arrivals
If you arrive late for an appointment, if the schedule allows, we will see you. There may be a lengthy wait however, as we will see all on-time patients first. If there isn't any flexibility in that day's schedule, you will be asked to wait if it is for urgent care or to reschedule if the problem is not urgent.

No-Shows
If you must miss an appointment, please call us as soon as you know you cannot make it. If you no-show for your appointment you will be billed a $50 non-refundable no-show fee. If you no-show for a complete annual physical, the fee will be $175. Patients who habitually do not show and do not contact us take time away from other patients and may be asked to find another provider.

Urgent Visits
If you have an urgent problem, we will do our best to accommodate you. In this situation, be aware that there may be a lengthy wait once you arrive at our office. Usually we will see you within 30 minutes of your scheduled appointment time, but occasionally the wait may be much longer.

I have read and understand the above information regarding the office policy for no-show and late appointments.

Patient Name:_____

Signature:_____ Date:_____

Name of Parent or Legal Guardian if patient is under 18:_____

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Credit Card Authorization for PAYMENT GUARANTEE

Our office now requires a credit or debit card on file; if we will be billing your insurance. When your portion of the bill is determined, we will charge your credit/debit card on file.

These charges are for all applicable co-payments, co-insurance, amounts applied by your insurance towards your deductible, non-covered services, and charges resulting from services rendered during any period that your insurance was not in effect for any reason.

If for any reason your insurance was not in effect on the day of service you are responsible for all charges. This may occur if you fail to pay your insurance premium and your insurance is cancelled retroactively. We will automatically charge your credit card when we verify from your insurance company that your insurance was not in effect on the day(s) of service.

By signing this form, you are authorizing Adolescent-Young Adult Medicine of Great Neck, LLC to charge your credit card for all payments for which you are financially responsible.

Patient Name: _____

_____
Name on Card

_____ _____
Signature **Date**