Office Policies:

Insurance Information, Co-Payments, Co-insurances, and Deductibles

Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. If you have not yet met your annual deductible, you will be charged $50 at the time of your visit. As a new patient visit or a physical exam, you will be charged $100 if you have not yet met your deductible. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. Any outstanding balance such as co-pay/co-insurance, deductibles, denials due to change in coverage or non-participating plans is patient responsibility. Outstanding patient responsibility older than 60 days after the due date on the billing statement will be charged a late fee of $25 per month on any outstanding balance.

I understand that I will be expected to pay for any and all fees associated with vaccinations, injections, or office procedures that my insurance does not cover. I agree to pay for all fees associated with the office visit and procedures, vaccinations, or injections should my insurance not provide coverage or should I not have coverage.

Your signature below affirms your understanding and willingness to comply with this policy.

Patient's Signature: _____ Date: _____

Assignment of Benefits

I hereby assign my insurance benefits to be paid directly to the above named physician(s). I understand I am financially responsible for all non-covered services.

Patient's Signature: _____ Date: _____

PCP Assignment

Please be advised that if your insurance requires a selection of Primary Care Physician (PCP), it is your responsibility to call your insurance company and designate Dr. Ali-Pennock or Dr. Levinskaya as your PCP prior to your first appointment. If you fail to do so, your insurance company will deny the payment and you will be responsible for the payment in full.

Your signature below affirms your understanding and willingness to comply with this policy.

Patient's Signature: _____ Date: _____

Referrals/Authorizations

If your insurance company requires a referral to a specialist, you MUST be seen for an office visit. Referrals will not be given over the phone. Once the physician decides that the referral is necessary, one will be generated based on the diagnosis from that visit. It is your responsibility to inform the front desk staff if a referral is required in order for them to work on submitting one for you. Please allow 7 days notice for the authorization/referral to be completed and for approval from your insurance company.

Your signature below affirms your understanding and willingness to comply with this policy.

Patient's Signature: _____ Date: _____

Cancellation Policy and No-Show Fee

Please be advised that we require 24 hours cancellation notice prior to your scheduled appointment. Failure to notify our office of a cancellation will result in a $25.00 fee. Please understand this is to discourage lost time for the doctors and other patients who have scheduled appointments. We appreciate your understanding.

Your signature below affirms your understanding and willingness to comply with this policy.

Patient's Signature: _____ Date: _____

Phone Calls Policy

It is the office policy that the physician will not be answering phone calls from patients during patient hours or while in the exam room with another patient, unless there is an emergency. Messages can be left for the physician(s) and they will make an effort to return them at the end of the day, and if not possible, by the following business day. The doctors will NOT return your phone call when no reason is given for the call. You MUST give a reason for documentation purposes in your chart; otherwise the front desk cannot take the message. Please do not assume that the doctor knows the reason for your call. Calls are returned at the end of the day in order of medical importance.

If you require a lengthy phone consultation (i.e., want to discuss medications, ask questions regarding blood work results), a fee of $30 will be billed to you, or alternatively you can make a follow up appointment to discuss. Our reason for this policy is that we make every effort to thoroughly address complaints at the time of the appointment and try to minimize interruptions while in the room with patients.

Any questions pertaining to billing, appointments, referrals, authorizations, medication refills, and faxes/emails to this office or to other offices, please address the front desk staff and they will be happy to help you.

No new complaint will be addressed over the phone. This is neither appropriate, nor safe, for you as the patient. Please make an appointment to be seen if there is something you would like to address.

Antibiotics will NOT be called in to a pharmacy outside of office hours. If you have symptoms you feel require treatment with an antibiotic, you MUST be evaluated by a physician. If we are unable to see you due to it being outside of our office hours, you may call to speak to the doctor on call. However, if antibiotics may be necessary, you will be referred to be evaluated by a physician at either an urgent care center or an emergency room depending on the symptoms. If the condition can wait, you may be asked to call the office on the next business day to make an appointment. Please be aware that this is done to ensure the safety of our patients. We will make every effort to accommodate sick visits to be seen on the same day, but cannot guarantee it.

Your signature below affirms your understanding and willingness to comply with this policy.

Patient's Signature: _____ Date: _____

Urine Toxicology

I give my consent to Primary Medical Associates of Long Island, PLLC (PMALI), to obtain a drug screen from me should the physician(s) feel it is necessary, via saliva or urine sample, as an initial diagnostic tool or to further aid in intervention/treatment with respect to the prescription of controlled substances. I understand that if I am requesting a controlled substance or if one is deemed appropriate for treatment, it is the office policy that a urine or saliva toxicology is **mandatory.** Refusal to allow us to obtain a sample will result in no further prescriptions for controlled substances being given to you by this office. Screening may be unscheduled (random).

I am aware that a positive screen may result in action, including but not limited to an increased level of care, a need for more frequent follow up, or possibly termination of our services and release from our practice and/or possible legal consequences. I understand that should my insurance not cover the cost of the toxicology, I will be expected to pay the office lab fee of $30 and any associated fees to the laboratory conducting the testing. I consent to the forwarding of my results to federal agencies, if necessary. I am aware that these specimens may need to be obtained in the presence of a staff member, to prevent falsification of the specimen, and that this is subject to the doctor's discretion.

Please be aware that the physician(s) practice with the utmost discretion related to your privacy and the use of controlled or illicit substances.

Your signature below affirms your understanding and willingness to comply with this policy.

Patient's Signature: _____ Date: _____

Release of Medical Information/Results

May we leave a message with test results on your answering machine/voicemail? YES _____ NO _____

If YES, what phone number may we leave messages? _____

Is there someone we are allowed to speak to regarding your medical condition(s) or results? YES _____ NO _____

If YES, please give us the name of the individual(s) and your relationship to them _____