ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY POLICY

The privacy policy of NY Pelvic Pain and Minimally Invasive Gynecologic Surgery, P.C. can be viewed by going to http://www.pelvicpainnewyork.com/privacypolicy.php, by obtaining a copy in the office located at 90 Maiden Lane Suite 300, or by requesting copy sent via US mail, email, or fax.

Federal law requires that we seek your acknowledgment of receipt of this Notice of Privacy Practices. Please sign below. I acknowledge that I have received this Notice of Privacy Practices with an effective date of December 1, 2006, and that I understand that if I have any questions regarding this Notice, I may contact the Privacy Officer.

Signature:___________________________________Date: _____________________________________

Printed Name: _______________________________

Signature of Parent/Guardian (specify which) if patient under 18___________________________

Date____

By signing in any area below I understand the following charges associated with being a patient at NY Pelvic Pain and Minimally Invasive Gynecologic Surgery, P.C.*

- **$40 charge for missed appointments or appointments cancelled with <24 hours notice.**
- **$15 charge for filling out disability forms associated with surgery or any illness.**
- **$30 returned check fee (in addition to the amount of the original check).**
- **Payment is expected at the time of service. If your balance if more than 90 days overdue and collections services are required to settle your balance then you may be subject to a 35% additional charge over the total of your account balance.**
- **$250 fee for cancelling office surgery within 48 hours and hospital surgery within 5 days of the procedure.**

***These fees are subject to change without notice.**

Credit Card Agreement

In order to guarantee full payment is made we require all patients to maintain a credit card on file.

Periodically, the co-pay on your insurance company's final explanation of benefits may not reflect what is stated on your insurance card. Thus, we often are required to bill small amounts. Submitting your credit card information to our secure file makes this process easier as you are responsible for all charges not covered by insurance. Should your balance be over $250 you will receive an email before a charge is made to your credit card.

Name__________________________________ Credit Card Type: Visa / Mastercard / Discover / American Express

Card #____

Expiration Date: ____

I authorize NY Pelvic Pain and Minimally Invasive Gynecologic Surgery, PC to charge my credit card for statement remainder balances.

Signature ____ Date___________________

Please read the following and sign below:

Assignment of Benefits and Release of Information

I hereby authorize my insurance benefits to be paid directly to Dr. Kenneth A. Levey and / or NY Pelvic Pain and Minimally Invasive Gynecologic Surgery, P.C. I understand that I am financially responsible for any and all non- covered services. I authorize the release of any medical or other information necessary to process insurance claims on my behalf.

Signature ____

Date_______________________________________

Medicare Patients

I hereby authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for any Medicare claim associated with the care provided to me by Dr. Kenneth A. Levey and / or NY Pelvic Pain and Minimally Invasive Gynecologic Surgery, P.C. I request that payment of authorized Medicare benefits be made either to me or to the party who accepts assignment.

Signature____ Date _______________________