Mount Sinai Doctors

PLACE LABEL HERE

AUTHORIZATIONS AND ASSIGNMENTS

1. FINANCIAL AGREEMENT/GUARANTEE OF PAYMENT (All Patients)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. _____ _____ (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website, can be provided to me upon request, and may be posted in the office.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though they may be employed by, contracted by, or affiliated with Mount Sinai Health System hospitals or facilities. I understand that I can determine the health plans participated in by physicians who are employed by, are contracted by, or are affiliated with Mount Sinai Health System hospitals or facilities by visiting http://www.mountsinai.org/patient-care/find-a-doctor . I also understand that I can determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting those facilities' web portals at www.mountsinaihealth.org/insuranceinfo

I understand that laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services provided in connection with my care may not be billed by the Physicians, and may be billed separately by the laboratories/facilities/providers who provide those services (even if those services are provided by Mount Sinai Health System facilities, laboratories, or providers). I further understand that laboratories/facilities/providers who provide laboratory (lab work), pathology, radiology, anesthesiology, and assistant surgeon services may or may not be participating providers in my health care plan network, that I can obtain the contact information for any such laboratories/facilities/providers whose services may be needed in connection with my care from the Physicians, and that I can contact those laboratories/facilities/providers directly to obtain information regarding their health plan participation.

I understand that if I elect or choose to obtain services from a provider who I know or who has been disclosed (in writing, on a website, and/or at the time my appointment was made) as not participating in my health plan network, I will be responsible for any and all charges billed by that provider to me. I further understand that if the Physicians do not participate in or with my health plan and/or network, the amount or estimated amount that the Physicians will bill for healthcare services can be made available to me in advance, upon request.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

_____ _____

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

_____ _____

RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE