SOMERS ORTHOPAEDIC SURGERY & SPORTS MEDICINE GROUP, P.L.L.C.

664 Stoneleigh Ave, Suite 300	2 Victory Court	657 E. Main St., Ste. 3
Carmel, NY 10512	Newburgh, NY 12550	Mt. Kisco, NY 10549
(845) 278-8400	(845) 565-1454	(914) 666-5550

OUR PRACTICE PAYMENT POLICY

MANAGED CARE / HMOs

We participate with most HMOs. It is the Patients or Authorized Representative (Parent or Legal Guardian for Minors) responsibility to provide Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. with his or her insurance information, Copy of the Insurance Card(s) and Referral. If the Referral is not available at the time of visit, then you will be required to pay for the visit. If you are able to obtain a valid Referral after the visit, you will be reimbursed for the payment (*less co-pay*) you made for the services rendered. Payment for co-pay's will be collected at each visit.

MEDICARE

Our participation in Medicare includes Physician and X-Ray Services. Medicare Patients are responsible for payment of the Medicare 20 % Co-insurance and the Medicare Deductible when applicable.

WORKERS' COMPENSATION / NO - FAULT

It is the Patients responsibility to bring all Workers' Compensation / No - Fault Insurance and Attorney Information with them at the time of the visit.

PRIVATE INSURANCE

If you are not covered under any of the above Insurance Plans, Payment for the Initial Consultation Fee, Office Visit and / or X-Ray(s) is required on the day of your appointment. We will mail you an itemized Receipt to submit for Reimbursement to your Insurance Company if requested.

UPDATES

It is the patient's responsibility to notify Somers Orthopaedic immediately of any change in their insurance or Empoyment Status to ensure accurate submission of claims.

PAYMENT

Payment may be made by cash, Check or Credit Card. We accept American Express, Discover, MasterCard and Visa.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS:

I have completed this Patent Registration Form and state that all of the information I have provided is valid and true. I have read and understand the Payment Policy of Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C.

I understand that payment is due on the date service are rendered and that if my Insurance Carrier does not pay the balance in full, I am personally responsible for the remaining Balance and I will pay any Balance promptly.

I hereby authorize Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C. to release any information acquired by them for purposes of Treatment, Payment and Healthcare Operations. I hereby authorize Payment(s) to go directly to Somers Orthopaedic Surgery & Sports Medicine Group, P.L.L.C.

PATIENT NAME: ______________________________ **D.O.B.** ____________

AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN ______________________________
(PRINT NAME & RELATIONSHIP)

SIGNATURE ______________________________ **DATE** ____________
PATIENT / AUTHORIZED REPRESENTATIVE / PARENT / LEGAL GUARDIAN - *For Minors*)