LONG ISLAND LAPAROSCOPIC DOCTORS

631-476-9296 PHONE 631-476-9298 FAX

PLEASE FILL OUT COMPLETELY

PATIENT

LAST NAME _____ HOME PHONE _____

FIRST NAME _____ MI _____ CELL PHONE _____

STREET _____ SEX: M F AGE: _____ MARITAL STATUS _____

CITY/STATE/ZIP _____ BIRTH DATE _____ SS# _____

PATIENT EMPLOYER _____ BUSINESS PHONE _____

ADDRESS _____ OCCUPATION _____

EMAIL ADDRESS: _____

By providing your email address you agree to receive by email address information about your healthcare including protected health information.

SIGNATURE PATIENT/GUARDIAN **PRINTED NAME** **DATE**

SPOUSE

NAME _____ BIRTHDATE _____ SS# _____

SPOUSE'S EMPLOYER _____ BUSINESS PHONE _____

STREET _____ OCCUPATION _____

CITY/STATE/ZIP _____

PRIMARY CARE PHYSICIAN _____ **EMERGENCY CONTACT** _____

STREET: _____ STREET: _____

CITY/STATE/ZIP _____ CITY/STATE/ZIP _____

PHONE _____ FAX _____ PHONE: _____

PHARMACY NAME: _____ RELATIONSHIP TO PATIENT: _____

PHARMACY PHONE: _____ FAX _____

Patient Name _____

PRIMARY INSURANCE

INSURANCE NAME _____

CLAIMS ADDRESS _____

CITY/STATE/ZIP _____

BIRTHDATE _____ SS# _____

ID # _____

SECONDARY INSURANCE

INSURANCE NAME _____

CLAIMS ADDRESS _____

CITY/STATE/ZIP _____

BIRTHDATE _____ SS# _____

ID# _____

ALL PATIENTS MUST SIGN

ASSIGNMENT&RELEASE:

I the undersigned, have insurance coverage with _____

I assign directly to Dr. Atwa, Tech Medical Office PC, Belle Meade Medical PC, Setauket Surgery PC, Setauket Medical PC, and Riverhead Surgery PC all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure payments of benefits I authorize the use of this signature on all my insurance submissions.

_____

SIGNATURE OF INSURED/GUARDIAN **PRINTED NAME** **DATE**

MEDICARE PATIENTS ONLY

MEDICARE AUTHORIZATION: I request that payment of authorized Medicare benefits be made to Dr. Atwa, Tech Medical Office PC, Setauket Surgery PC, Riverhead Surgery PC and Setauket Medical PC for services furnished to me by Dr. Atwa, Tech Medical Office PC, Setauket Surgery PC, Riverhead Surgery PC, Setauket Medical PC, I authorize any holder of medical information about me to release to the health care financing administration and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim If "other health insurance" is indicated in item 9 of the CMS-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases the physician agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible for the deductible co-insurance and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

SIGNATURE OF INSURED/GUARDIAN **PRINTED NAME** **DATE**

LI LAPAROSCOPIC DOCTORS
4 Technology Drive, Suite 220, East Setauket, NY 11733

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

BELLE MEADE MEDICAL, PC
248 ROUTE 25A, SUITE 26
EAST SETAUKET, NY 11733
PHONE: 631-476-9296
FAX: 631-476-9298

FINANCIAL ASPECTS OF OUR RELATIONSHIP

INSURANCE PLANS

Belle Meade Medical, PC participates with Aetna, Cigna, Magna Care, Health First, Fidelis, Oscar, 1199 and GHI. Participating with these insurance companies means that we have agreed to accept their contracted rate with the exception of anything that would be considered the patient's responsibility according to your contract with your insurance carrier. The patient's responsibility portion may include, but is not limited to; copayment, coinsurance, or deductible.

PPO INSURANCE PLANS

Most insurance plans offer a PPO (Preferred Provider Organization) option. Belle Meade Medical PC is able to see patients with this type of plan by accessing the Out of Network Benefits available under the policy. This means that your insurance company would apply your deductible (if not already met), once that deductible is satisfied your insurance would pay the percentage as noted in your contract and you are responsible for the percentage of coinsurance as noted in your contract. Your PPO Insurance Carrier may send all correspondence and checks to you directly. These payments must be forwarded to our office within 30 Days of being issued by your insurance carrier.

HMO INSURANCE PLANS

HMO policies require that you use physicians and facilities that participate with that insurance carrier. Belle Meade Medical, PC participates with Aetna, Cigna , Health First, Fidelis, Magna Care Oscar, 1199 and GHI PPO. If you have an HMO Insurance Carrier not listed above, Belle Meade Medical, PC will not be reimbursed by your Insurance Carrier for office services rendered unless a prior authorization has been obtained from your Insurance Carrier or as otherwise defined by your contract with your insurance carrier. If you have an HMO Plan and received services as a result of a visit to the Emergency Room or Hospital Consultation at John T. Mather Memorial Hospital, St. Charles Hospital, St. Catherine of Siena Medical Center or Peconic Bay Medical Center your HMO policy will cover out of network services and in most cases the patient is held harmless from any financial responsibility. Your HMO Insurance Carrier may send all correspondence and checks to you directly. These payments must be forwarded to our office within 30 days of being issued by your insurance carrier.

NUTRITIONAL VISITS

If your insurance plan does not cover Nutritional Visits you can still utilize our services. However, you will be asked to pay out of pocket for these services. The fees are as follows: for initial visits $100.00 and for continuing visits $50.00 to be paid at the time of the visit. We accept Cash, Money Order, Debit and Credit Card Payments.

REQUESTS

If your insurance carrier requests additional information from you which may include but is not limited to; coordination of benefits, student verification information and/or a questionnaire regarding pre-existing conditions, workers compensation injury and no-fault services, it is your responsibility to comply with their request, in the specified time frame according to your contract with your insurance carrier and/ or state law. Failure to comply with the request may result in a denial of your services and transfer the financial responsibility to you.

There will be a $20.00 office service charge for all checks returned for insufficient funds.

PAST DUE ACCOUNTS

All accounts which are over 30 days from Insurance Carrier payment and past patient responsibility will accrue a service charge of $10.00 per month. After 60 days past due your account will be forwarded to collections for the account balance as well as attorney and collection fees which are presently 29% effective 1/1/2012.

I have read the Financial Aspects of Our Relationship stated above. By signing I agree to its terms.

_____ _____
Print Patient or Responsible Party Date

_____ _____
Signature of Patient or Responsible Party Date

LONG ISLAND LAPAROSCOPIC DOCTORS
4 TECHNOLOGY DRIVE, SUITE 220 PHONE: 631-476-9296
EAST SETAUKET, NY 11733 FAX: 631-476-9298

FINANCIAL ASPECTS OF OUR RELATIONSHIP

INSURANCE PLANS

Hesham M Atwa, Physician PC, Tech Medical Office, PC, Setauket Surgery, PC and Riverhead Surgery, PC participate with Medicare Part B. Participating with this insurance means that we have agreed to accept their contracted rate with the exception of anything that would be considered the patient's responsibility according to your contract with your insurance carrier. The patient's responsibility portion may include, but is not limited to; copayment, coinsurance, or deductible.

PPO INSURANCE PLANS

Most insurance plans offer a PPO (Preferred Provider Organization) option. Hesham M Atwa, Physician, PC, Tech Medical, PC, Setauket Surgery, PC and Riverhead Surgery, PC are able to see patients with this type of plan by accessing the Out of Network Benefits available under the policy. This means that your insurance company would apply your deductible (if not already met), once that deductible is satisfied your insurance would pay the percentage as noted in your contract and you are responsible for the percentage of coinsurance as noted in your contract. Your PPO Insurance Carrier may send all correspondence and checks to you directly. These payments must be forwarded to our office within 30 Days of being issued by your insurance carrier.

HMO INSURANCE PLANS

HMO policies require that you use physicians and facilities that participate with that insurance carrier. If you have an HMO Insurance Carrier not listed above the physician will not be reimbursed by your Insurance Carrier for office services rendered unless a prior authorization has been obtained from your Insurance Carrier or as otherwise defined by your contract with your insurance carrier. If you have an HMO Plan and received services as a result of a visit to the Emergency Room or Hospital Consultation at John T. Mather Memorial Hospital, St. Charles Hospital or St. Catherine of Siena Medical Center,Stony Brook Southampton Hospital and Peconic Bay Medical Center your HMO policy will cover out of network services and in most cases the patient is held harmless from any financial responsibility. Your HMO Insurance Carrier may send all correspondence and checks to you directly. These payments must be forwarded to our office within 30 days of being issued by your insurance carrier.

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I have read the Financial Aspects of Our Relationship stated above. By signing I agree to its terms.

_____ _____
Signature of Patient or Responsible Party DOB

_____ _____
Print Name of Patient or Responsible Party Date

Hesham M. Atwa, M.D.
Tech Medical Office, PC.
Belle Meade Medical, PC.
Setauket Surgery, PC.
Riverhead Surgery, PC.

General Surgery, Advanced Laparoscopy & Bariatrics

4 Technology Drive, Suite 220
East Setauket, NY 11733
631-476-9296 Phone
631-476-9298 Fax

PATIENT FINANCIAL RESPONSIBILITY
ASSISTANT SURGEONS

Most surgical procedures require an assistant surgeon be at the procedure. If an assistant surgeon is needed, your insurance company will be billed for my services and also by the assistant surgeon.

MANY PPO INSURANCE PLANS WILL SEND ALL CORRESPONDENCE AND CHECKS TO YOU DIRECTLY. THESE PAYMENTS MUST BE FORWARDED TO THE ASSISTANT SURGEONS OFFICE.

You will receive a statement from the assistant surgeon requesting this payment. If you do not turn over these payments to the appropriate physician, your account will be forwarded to collections. At that time the responsible party (i.e. patient or guarantor) will be held responsible for all collection costs and attorney fees.

I understand that I am responsible for forwarding all insurance checks to the assistant surgeon used at my surgical procedure. I further understand that if I do not forward payment to the assistant surgeon, I will be responsible for all collections costs and attorney fees related to this claim.

_____ _____

Printed Name Date

_____ _____

Signature of Patient or Responsible Party Date