Podiatric Surgical Associates
1 West 85th Street, Suite 1C, New York, NY 10024

Dr. Edwin W. Wolf, DPM Dr. Catherine N. Lee, DPM Dr. Arianna Sabghir, DPM

AUTHORIZATIONS AND ASSIGNMENTS

PATIENT NAME: ______________________________ **PATIENT DOB:** ______________________

1. FINANCIAL AGREEMENT / GUARANTEE OF PAYMENT (All Patients) (*PLEASE INITIAL*) ☐ **YES** _____ ☐ **NO** ______

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by **Podiatric Surgical Associates** ('the Providers') with respect to such services and care unless the contract between the Providers 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 agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Providers, 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 **Podiatric Surgical Associates** immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION (*PLEASE INITIAL*) ☐ **YES** _____ ☐ **NO** ______

In the event my issuer denies payment to the Providers for services rendered to me, I hereby give my consent to have an authorized representative of the Providers to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Providers which may be required in order for my insurer to reevaluate its decision to deny payment for such services. A complete HIPAA Notice of Privacy Practices is available upon request.

I authorize this practice, my treating Providers, 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).

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

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

I understand that the Providers may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though the Providers may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by providers who are employed or contracted by Mount Sinai Health Systems to provide hospital / facility services 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 the facility's web portal.

I understand that the Providers charge for their services separately from the hospital and facilities in the Mount Sinai Health System, and that any bills from the hospital or facilities in the Mount Sinai Health System and for so-called "facilities" or "technical" fees will be sent separately from the Providers bills for their "professional" services.

I understand that it is my responsibility to check with the "provider" arranging for my services regarding: (1) whether the services of any other providers will be required for my care; and (2) whether the services of any other providers (including but not limited to anesthesiologists, pathologist, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "provider" arranging for my services to obtain the contact information and/or health plan participation information for any providers or facility whose services may be needed in connection with my care, and that I can also contact those providers directly to obtain information regarding their health plan participation.

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

______________________________________ ______________________
SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE DATED

______________________________________ ______________________
RELATIONSHIP TO PATIENT WITNESS TO SIGNATURE