John J. Leppard, M.D., F.A.A.O.S., F.A.C.S.
Certificate of Added Qualification in Surgery of the Hand
Lee M. Kupersmith, M.D., F.A.A.O.S.
Jonathan R. Mallen, M.D., F.A.A.O.S.

John P. Downey, *Administrator*

ORTHOPAEDIC & SPORTS ASSOCIATES of Long Island

Board Certified • Fellowship Trained

- Hand, Upper Extremity & Shoulder
- Hip & Knee Replacement
- Arthroscopy & Sports Medicine
- Ankle & Knee Disorders
- General Orthopaedics Pediatric & Adult
- Back & Neck Pain

AUTHORIZATION/SIGNATURE ON FILE I authorize the use of this form for all of my insurance submissions, release of information to all of the insurance companies or adjustor involved in this case. I authorize payment directly to ORTHOPAEDIC & SPORTS ASSOCIATES OF LONG ISLAND, at the address designated by the practice. I permit a copy of this authorization to be used in place of an original. I authorize ORTHOPAEDIC & SPORTS ASSOCIATES OF LONG ISLAND to issue a complaint to the Insurance Commissioner for any reason on my behalf. I authorize ORTHOPAEDIC & SPORTS ASSOCIATES OF LONG ISLAND to act as my agent in helping me obtain payment from all of my Insurance Companies; this is a direct assignment of my rights and benefits under the above policy.

FINANCIAL POLICY In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

YOUR INSURANCE We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay any amount put to your responsibility per the explanation of benefits. It is the policy of our office to collect the co-payment when you arrive for your appointment. If you have insurance coverage with a plan that we do not have a prior agreement we will prepare and send the claim for you on an unassigned basis. Your insurer will send the payment directly to you and you are responsible to sign over the check along with any EOBs that relate to your services. Patient will be responsible for deductible and nay balance from your insurance carrier. In the event that your health plan determines a service to be "not covered"; you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. It is the patient's responsibility to obtain the necessary referral or authorization needed by your insurance company in order to be seen. If this information is not on file with the insurance carrier and you would like the be seen, than you will be responsible for all services rendered during the office visit.

PATIENT AUTHORIZATION SIGNATURE FORM "I hereby authorize any physician, health care practitioner, hospital, clinical or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation or evaluation of any claim submitted by my insurance carrier. I also authorize my insurance carrier to disclose information to a hospital or healthcare service plan, self-insurer or any medical information obtained if such disclosure is necessary to allow processing of the claim. If my coverage is under a Group Contract held by an employer, an association, trust fund, union or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

ACKNOWLEDGMENT FORM I acknowledge that the Notice of Privacy Procedures is posted in plain sight for my viewing in this office and I have been provided an opportunity to review it.

PATIENT RECORD OF DISCLOSURE

I wish the be contacted in the following manger (check all that apply)

☐ Home # _____ ☐ Work # _____ ☐ Cell # _____

Signature Written Communications: ☐ Mail to home address ☐ Mail to business address

I authorize you to contact or speak to the following individuals regarding my care and/or billing inquiries: _____

_____

"I verify the accuracy of the above information and I authorization the release of information as provided on this form. I also authorization the assignment of benefits directly to ORTHOAPEDIC & SPORTS ASSOCIATES OF LONG ISLAND. I understand that I am financially responsible for the treatment rendered. I hereby authorize ORTHOAPEDIC & SPORTS ASSOCIATES OF LONG ISLAND to submit a claim to the insurance carrier or its intermediaries to issue payment check(s) directly to ORTHOAPEDIC & SPORTS ASSOCIATES OF LONG ISLAND."

SIGNATURE: _____ Date: _____