HUDSON VALLEY SURGICAL GROUP, L.L.P.
OUR FINANCIAL POLICY

Thank you for choosing **Hudson Valley Surgical Group, L.L.P.** as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read, and sign prior to any treatment.

All patients must complete our Information and Insurance form before seeing the doctor.

Please understand that insurance reimbursement can be a long and difficult process for our office. In fact, insurers will routinely stall, deny, and reduce payments. To that end, our billing staff has undergone extensive and rigorous training to maximize your insurance reimbursement, while reducing the time by which they pay.

ALL COPAYMENTS ARE DUE BEFORE SERVICES RENDERED. WE ACCEPT **Check, Cash, Money Orders, MasterCard or Visa.**

Regarding Insurance We will accept assignment of insurance benefits if we participate in the insurance companies' network. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services are not considered reasonable and necessary under the Medicare Program and/or other medical insurance.

Regarding Insurance Plans where we are a participating provider. All co-pays are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, you will be responsible for any amount not covered by your insurance.

Please Note: Your surgical procedure may require an assistant surgeon who does not participate in your insurance plan.

For patients who do not have insurance, full payment is expected before services are rendered. Payment plans will be arranged if further services are required.

Usual And Customary

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. (This applies only to those patients who choose to go out of network).

Adult Patients

Adult patients are responsible for full payment at time of service.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied.

Late Fee

We reserve the right to charge a $10.00 late fee if co-payments are not paid at the time of visit and become 60 days delinquent.

Self Pay Balances, Insurance Co-pay and Deductible (any non-covered services):

are due thirty days after services are rendered. Unpaid amounts are subject to late fees accrued at 1 ½% monthly. Patient will be responsible for all reasonable third party collection and legal fees if the balance becomes delinquent.

Insurance Assignment

Commercial Insurance

"I hereby assign medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Private Insurance and any other Health Plans to **Drs. Robert Raniolo and/or Har Chi Lau and/or Michael Weitzen** and/or assistant surgeons for services rendered to me or for my benefit by or under the authority of any one or more of them. This agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as an original. I understand that I am financially responsible for all lawful charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

No Fault Insurance/Workers Compensation Insurance

"I hereby authorize **Drs. Robert Raniolo and/or Har Chi Lau and/or Michael Weitzen** to furnish all information he may have regarding my condition while under his observation or treatment, including the history obtained, x-ray and physical findings, diagnosis and prognosis. He is authorized to provide this information in accordance with the New York Comprehensive Automobile Insurance Reparations Act (No Fault Law), and State of NY Worker's Compensation Board.

Medicare B Insurance

"I request that payment of authorized Medicare benefits be made on my behalf to this office for any services furnished by that physician to me. 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 or the benefits payable for related services."

"Authorizations applies to all occasions of service performed by Robert Raniolo, M.D. and/or Har Chi Lau, M.D. and/or Michael Weitzen, D.O. and/or assistant surgeons, until it is revoked" "I further authorize you to give me reasonable and proper medical care by today's standards"

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X _____ Date _____

Signature of Patient or Responsible Party