

PEDIATRIC CARDIOLOGY OF LONG ISLAND, P.C.

100 PORT WASHINGTON BOULEVARD, ROSLYN, NY 11678 516-365-3340 – Fax: 516-365-5512
 5505 NESCONSET HIGHWAY, MT. SINAI, NY 11766 631-331-5014
 500 WEST MAIN STREET, BABYLON, N.Y. 11702 631-669-9624
 70-31 108TH ST., FOREST HILLS, NY 11375 718-520-5464
 70 C OLD RIVERHEAD ROAD, WESTHAMPTON BEACH, NY 11978 516-365-3340

MILTON J. REITMAN, M.D.
 AMBROSE M. VALLONE, M.D.
 SEAN G. LEVCHUCK, M.D.
 DOUGLAS M. LUXENBERG, D.O.

OUR OFFICE POLICY

We appreciate your confidence in choosing Pediatric Cardiology of Long Island. Please take a moment to review our office financial policy below:

CO-PAYMENTS: If you are an enrollee of a managed care plan (HMO, POS, PPO) that we are contracted with, you are required to pay the co-payment each time you are seen. This must be paid prior to being seen. If you are not prepared at the time of service, there will be a \$5.00 surcharge imposed.

ANNUAL DEDUCTIBLES: In addition to the co-payments, some plans have annual deductibles. You are required to pay at the time of service if it has not been satisfied. IN the event that there is a balance after the insurance carrier has paid its portion, the billing office will bill you. It is the office policy to send five bills. After 90 days your account will incur finance charges. Your last statement will advise you that the balance will be turned over to a collection agency. To avoid this, please pay your bill promptly. If you do not understand the reason for the balance, please do not hesitate to contact the office.

REFERRALS: if you are enrolled in an HMO, which requires a referral from your Primary Care Physician, you must have that referral at the time of service. If you arrive without it, a financial waiver can be signed or the appointment can be rescheduled.

It is the responsibility of the patient to be familiar with their insurance policy. It is impossible to get any guarantee of payment until a claim is submitted. Therefore, the patient/parent/guardian is liable for any charges that are not covered under their contract.

MEDICAL RECORDS: All requests for medical records must be in writing. Upon receiving request and if records are current, they will be available in one week's time. If records are in storage, it will take one month for availability.

Please sign below and return to our staff.

I have read the above and understand my obligations.

Signature of Patient/Parent/Guardian

Date

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FINANCIAL WAIVER

In consideration of services rendered by Dr. _____ to the undersigned patient, the undersigned promise(s) to pay Dr. _____ any co-payment, coinsurance or other charges required to be paid by my health insurance coverage. In addition, I promise to pay for all services/procedures (i.e.: pulse ox, ekg, etc) that are not covered by my health insurance plan provided I am informed to same prior to rendering of said services.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN

DATE _____

SIGNATURE OF AUTHORIZED REPRESENTATIVE OF
Pediatric Cardiology of Long Island

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RECEIPT OF NOTICE OF PRIVACY PRACTICES

WRITTEN ACKNOWLEDGMENT FORM

I, _____ have received a copy
of Pediatric Cardiology of Long Island's Notice of Privacy Practices.

I, _____ am over 18 and give
permission for any test results and health information to be shared with
_____ who is my _____.

Thank you.