

DR. CAROL M. RUSSELL PC
131 FOREST AVENUE
STATEN ISLAND, NEW YORK 10301
(718) 442 - 7700

PATIENT: _____

TO PATIENTS PRESENTING THEMSELVES WITH INSURANCE COVERAGE

Thank you for selecting me for your medical care. In order to prevent any misunderstandings concerning the responsibility regarding payment for any care, the following information is provided. This office has agreed to participate with several managed care companies. It is important for you to consult with your insurance company and our staff prior to your visit in order to determine which services, if any, are covered. If, for any reason, you are unable to meet your financial obligations for the care provided, please feel free to contact our billing office. We will do all that we can to help with your insurance coverage.

It is imperative that you keep this office informed of your current and effective insurance coverage. We expect you to provide us with accurate information for each date of service. If any changes occur in your insurance coverage, it is **your responsibility** to notify us as soon as possible. Our office will submit your bill **only once** to the carrier which was specified by you. If there is denial, delay, or any problem with payment from your carrier, you will be billed directly by this office and payment is expected promptly upon receipt of our notice. Any further attempts to collect from the insurance company will need to be done by you.

ACKNOWLEDGEMENT

RELEASE OF INFORMATION - I authorize release of any insurance information necessary to Dr. Russell in order to process any claim.

Insured or Authorized Person

Date

FINANCIAL RESPONSIBILITY - I have read, understand, and agree to the above policies. I do understand that charges not covered by my insurance company, as well as applicable co-payment and deductibles, are my responsibility. I understand that, in addition, if I do not utilize Dr. Russell, no coverage or "only out-of-network" coverage will be available from my insurance company for such services and that I will be solely responsible for all payments related to same. I also understand that in the event of nonpayment or partial payment from my insurance company, I am responsible for any unpaid balance. In the event of litigation, I will be responsible for all costs of suit including, but not limited to, court costs, collection fees and reasonable attorney fees.

I authorize the insurance benefits payable to me or my assignee to be paid directly to Dr. Carol M. Russell PC.

I authorize Dr. Russell to release pertinent medical information to my insurance company when requested, or, to facilitate payment of a claim.

Signature

Date

Print Last Name, First Name

Social Security Number