NEW YORK PAIN MEDICINE
AND PHYSICAL THERAPY

Acknowledgement and Consent for Treatment

I have been made aware of my condition by my health care provider and agree to have medical care performed at New York Pain Medicine and their therapy affiliates. The treatment will be in accordance with my diagnosis and in consultation with my physician or health care provider. I have also been provided with a copy of New York Pain Medicine's HIPAA Privacy Notice and have been given ample opportunity to read and ask questions about said notice.

Signed:_____
Date:_____

Release of Records and Payments

I authorize the release of medical or other information necessary to process my insurance claims. I authorize payment of medical benefits to the providers at New York Pain Medicine and their affiliates. I permit a copy of this authorization to be used in place of an original. I accept full responsibility for the full amount due for services provided to me. I understand that all insurance forms that I have signed may be sent to my insurance company or employer on my behalf. I understand New York Pain Medicine and affiliates do not participate in the networks of any private insurance carrier. Any payments that are received by me for services rendered by New York Pain Medicine and their affiliates will be endorsed and presented immediately along with an explanation of benefits. I also understand that any insurance deductible or co-insurance is my responsibility to pay New York Pain Medicine. I also understand that I am responsible to present any information pertinent to the processing of any claims. If my insurance information changes, I must alert the office staff at New York Pain Medicine immediately.

Signed:_____
Date:_____

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Cancellation Policy

All cancellations require a minimum of 24 hours notice. If notice is not received within this time frame the patient will be held financially responsible for a $75.00 fee for each missed appointment. This **cannot** be billed to your insurance company. Outstanding balances must be settled before your next appointment.

If you need to cancel a Monday appointment you must leave a message on the office's voicemail over the weekend by calling 212-245-7900. Please note that the therapists and acupuncturists do not have the authority to edit/cancel appointments. If you feel that you may not be able to keep your appointment, it would be prudent to cancel in advance with the receptionist only. Therefore, please do not send emails or leave messages on your therapist's voicemail regarding your appointments.

This agreement applies to missed appointments due to weather conditions, transportation restrictions, family emergencies, personal/professional commitments and/or patient illness. Doctor's notes and/or emergency room visit/notes will not excuse you from this agreement. We consider your appointment effectively cancelled if you are 15 minutes late for your scheduled time. As such you will be held responsible for the $75.00 cancellation fee.

Please understand that missing an appointment for any of the aforementioned reasons denies another patient a valuable and necessary medical service. Therefore, this office finds it necessary to implement and enforce this policy without exception.

Please note that you are not obligated to sign this agreement. However, if you do not agree with this policy, advanced appointment scheduling will be prohibited. You will have to call on the day that you wish to come in for medical, therapy, or acupuncture to see if he/she has availability.

If you require clarification of this policy, please do not hesitate to contact us at 212-245-7900.

Signing your name below assures NY Pain Medicine that you have read, understood and agree to the terms of our policy.

_____ _____

Patient's signature Date

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CREDIT CARD AUTHORIZATION AGREEMENT

In the event that my insurance carrier denies payment for any reason or applies payment towards my deductible/co-insurance, I hereby authorize *New York Pain Medicine* (the "Practice") to charge my credit card only for the amount specified by my insurance carrier with the information I have provided below. *New York Pain Medicine* will provide me with a copy of the invoice of the charge within three (3) business days of the credit card transaction. I herein approve and authorize this credit card charge to satisfy my outstanding balance for monies owed to the Practice for my physical therapy and/or medical services.

In the event that my credit card has been charged with any balance and I have forwarded payment of my outstanding balance, the charges will be credited to my credit card by *New York Pain Medicine*.

My signature below ensures *New York Pain Medicine* that I understand the terms of this agreement.

Signature Date

Witness Date

Credit Card Information

Name as it appears on credit card

Credit card number Type of credit card

Expiration date

3-4 digit security code

Billing address that the credit card company has on file.

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Out of Network Health Care Plan

Please be advised that Dr. Allen and affiliates is a non-participating or "out-of-network" provider under your insurance plan. If you were referred to Dr. Allen and affiliates by another physician that is a participating or in-network provider under your health plan, please be advised that such referral does not change the non-participating or out of network status with regards to Dr. Allen and affiliates. As such, some or all of the costs for the medical care provided by Dr. Allen and affiliates may not be covered under your insurance policy or may be covered at a rate that is less than the amount Dr. Allen and affiliates bills for such services.

Please write the name of your health care insurance plan, sign and print your name and today's date to acknowledge that you are aware that Dr. Allen and affiliates is a non-participating (out-of-network) provider under your health care plan, that (if applicable) you consent to the referral to a non-participating (out-of-network) provider. You should discuss the fees and billing policy with that physician prior to your visit.

Health Care Plan Name: _____ Date:_____

Patient Signature: _____ Name:_____

Request for Estimate of Charges

Under New York State Law, you are entitled to request an estimate of the amount you will be billed for any treatment you receive from Dr. Allen and affiliates. In the even you elect to receive additional follow-up care from Dr. Allen and affiliates and you wish to request and estimate of the costs of such are, Dr. Allen and affiliates will provide you a written statement of the amount or estimated amount of the charges for such care, absent any unforeseen medical circumstances that may arise during the course of treatment. Please sign and print your name and date below to confirm that you can obtain this written statement from Dr. Allen and affiliates before such treatment is provided.

Patient Signature: _____ Date:_____