ALLEN
MEDICAL ASSOCIATES

1045 W. Jericho Turnpike, Smithtown NY 11787
Tel: 631-543-8844 Fax: 631-543-8840
www.allenmedicalassociates.com

PATIENT COVERAGE WAIVER

The undersigned ("you") stated you are covered by insurance. If you fail to provide your insurance information, provided the incorrect information, or failed to notify us of changes in your coverage, you will be financially responsible for the service provided to you if denied by your insurance carrier.

If your insurance plan requires you to choose a Primary Care Physician (PCP), you must be sure you have chosen Dr. Allen as your PCP. If you fail to update your PCP, you will be responsible for all service charges if denied by your insurance.

Your insurance company may require a referral to see a specialist. If your insurance plan requires you have a referral, it is your responsibility to have your PCP's office supply one for you. If you fail to obtain a referral before your visit, you will be held responsible for any bills your insurance refuses to pay. If you fail to pay your health insurance premiums, resulting in loss of coverage you will be responsible for all medical fees.

Please understand, it is not possible for our office to call every patient's insurance carrier prior to their visit to verify their coverage or chosen PCP. We must hold the patient responsible for updating any insurance information necessary.

I understand I am responsible to know what my plan covers and does not cover. I am aware that some insurance companies do not cover vaccinations, and it is my responsibility to know what vaccinations are or are not covered by my plan. I am aware that some insurance companies only cover physicals yearly, biannually, or not at all.

I understand that I am responsible to notify the staff if the reason for my visit is due to a motor vehicle accident or workers compensation. I am aware that this office does not participate with worker's compensation insurance.

I give full consent for my insurance company to pay directly to the Physician provider all charges arising from mine or my dependent's visits.

I agree that I will be liable for all fees not covered by my insurance. I also agree that if monies owed are not paid in a timely fashion I will be responsible for all costs associated in collecting those fees, including but not limited to all legal and collection fees. I hereby agree to leave a credit card or checking account information on file to be charged for any and all outstanding patient balances and fees over thirty days. I understand a $50 administrative fee maybe charged for any credit card charge backs. I understand copays are due at the time of services and that I will be charged a five dollar service fee per statement for unpaid copays.

I understand that any medical equipment loaned to me for my medical care is the property of Allen Medical Associates and must be returned as specified in the "equipment loan agreement". I understand I will be liable for the full replacement cost of the medical device if not returned within one week. I understand that the office requires 24-hour notice for all canceled or missed appointments. If such notice is not given I am aware that I could be charged a "No Show" fee of $75-$150 depending on the appointment type.

Accepted and agreed: _____ Date _____
(Signed, Patient or Legal Guardian)

_____
Print Name

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Acknowledgment of Notice of Privacy Practices

I have been presented with a copy of the Notice of Privacy Practice for the office of Allen Medical Associates detailing how my information may be used and disclosed as permitted under federal and state law.

DESIGNATED REPRESENTATIVE

I authorize discussion of my PHI (protected health information, including treatment, and payment) with:

( ) Spouse: _____

( ) Children: _____

( ) Other: _____

May we leave medical information on your home or work answering machine?

Yes (or) No

_____ _____
Patient Signature ***Date***

_____
Print Name

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Card on File: Authorization Form

Information to be completed by cardholder:
The undersigned agrees and authorizes Allen Medical Associates to save the credit card indicated below on file.

Medical Practice: _____

Patient's Name: _____

Name as it Appears
on the Credit Card: _____

Type of Credit Card: ☐ MasterCard ☐ Visa ☐ Discover ☐ Amex

Last 4 Digits of Card: ☐☐☐☐

Expiration Date: _____

I, _____authorize Allen Medical Associates to process the above credit card as "Card on File". I understand this authorization will remain in effect until the expiration of the credit card account. Patient may also revoke this form by submitting a written request to the medical practice.

_____ _____

Cardholder's Signature Date