NAME

Raphael S. F. Longobardi, MD, FAAOS
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Part 5: PATIENT FINANCIAL RESPONSIBILITY

Your Responsibility for Payment

I am responsible for knowing and advising Dr. Longobardi's office of my health insurance program's requirements in advance, each and every time service is provided. If my insurance has out of network benefits and these are utilized , I agree to pay any deductible and coinsurance. I understand that I am financially responsible for all charges for services rendered, whether or not paid by my insurance carrier(s). I am aware that my insurance company might not cover all charges associated with my care, ie. medical supplies. I agree to pay any such charges.

Authorizing Release of Information

I authorize the release of this and any information necessary to process any claims and to secure the payment of benefits.

Assignment of Payments

I also assign payment of claims directly to my physician (Raphael S. F. Longobardi, MD) or supplier for services rendered, if I have not paid these claims in advance. I also assign all workman compensation/no-fault claim payments to Raphael S. F. Longobardi, MD, for payment directly to him.

Event of non-payment

In the event of non-payment by the insurance carrier, I understand I am personally responsible for the full payment. Likewise, I will be responsible for all balances after insurance co-payment, if applicable. All balances are payable within 30 days of being billed, a 1-1/2 % (one and a half percent) late charge will be assessed per month for outstanding balances. If my account is not paid when due and is sent to an attorney or collection agency, then in addition to the balance on my account, I agree to pay a collection fee of $ 50 or 1/3 of the balance owed, whichever is greater and any reasonable attorney fees and expenses incurred for collection of charges related to services rendered.

I have read the above statement regarding my responsibilities toward my insurance carrier and Dr. Raphael S. F Longobardi, and agree to abide by the promises I made and that I am ultimately responsible for any fees which my carrier will not pay due to any failure to comply with their regulations.

I, the undersigned certify and verify the accuracy of all the above information.

Print Name

Date

Patient's/Guarantor's Signature

Date

Print Form

Receptionists initials