Mount Sinai

Department of Orthopedics
Mount Sinai Health System

Mount Sinai Orthopedics
Patient Waiver

Today's Date: _____

Patient Name: _____ (print)

MRN# _____

Provider: Dr. DR. WESLEY BRONSON

☐ Commercial/Union ☐ Medicaid ☐ Managed Medicaid ☐ Managed Medicare ☐ Self-Pay

Patients with Insurance Coverage Opting to be Self-Pay:

I understand Dr. _____ does not participate in my insurance plan. I also understand that I am responsible for payment for this date of service/service period from ___/___/___ to ___/___/___.

I was advised I can see a participating provider at minimal cost to me. I voluntarily agree and consent to receive treatment by an out-of-network physician. I understand I am responsible to pay for all services I receive at the time of service, and the provider will not file a claim to my insurance plan for the service(s) rendered to me.

Patients with NO Insurance Coverage:

I understand I am responsible for payment for this date of service period from ___/___/___ to ___/___/___ and payment is due from me at the time of service.

Financial Waiver

This is to acknowledge that I am financially responsible for charges not covered by my insurance carrier due to the physician's non-participating/out-of-network status with my insurance carrier or due to a lack of referral or prior authorization required for today's services should one not be present at the time of service. I acknowledge I am financially responsible for charges for lack of insurance information necessary at the time of service. I acknowledge that I am financially responsible for any deductible, coinsurance, or co-payment as well as any non-covered charges deemed my responsibility by my insurance carrier.

Patient's Signature: _____ Date: _____

Patient's Legal Representative Signature: _____ Date: _____

(If patient cannot sign)

Legal Representative's Name _____

(Print Name)

Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card**.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient Name:	**Patient Signature**:	**Date of Birth**:
Patient Address:	**City, State**:	**Zip**:
Today's Date:		
Guarantor Name: (if not the patient)	**Guarantor relationship to patient:**	**Guarantor Signature**: