FAMILY MEDICINE NYC, P.C.

150 BROADWAY • SUITE 1702
NEW YORK, NEW YORK 10038
TEL: 917-409-7575 • FAX: 917721-9037
EMAIL: FAMILYMEDICINENYC@GMAIL.COM

ADVANCED BENEFICIARY NOTICE
CONFIRMING PATIENT FINANCIAL OBLIGATION and
ADVANCED ENROLLE E NOTIFICATION

We value you as a patient and appreciate that you entrusted us with your health care needs. As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles, and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan to verify your eligibility and benefits as well as requirements for prior authorizations or referrals, but please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits.

In addition to your responsibility for, co-payments, co-insurance and deductibles, the following services are expected to be provided to you, and our experience with health benefit plans indicates that you may not be completely covered by all the services that you wish to receive. You will then be responsible for the cost of these services in addition to any other services that are denied or limited by your health benefit plan.

□ Coverage/Responsibility: _____

Since you are ultimately responsible for payment of the medical services provided to you, it is our office policy to obtain your credit card number and authorization to process a claim for payment should your health plan not honor the claim we submit for the services provided to you and for other patient responsibilities. In providing credit card information below, you authorize payment by credit card for services in the absence of coverage by your health benefit plan (including, but no limited to, coinsurance, deductibles, and preventative visit combine with other diagnosis or undiscovered services). Please be aware that we will not authorize payment of your credit card without your knowledge. We will inform you of your responsibility and allow you 1 business week to re-verify your responsibility with your insurance company prior to us submitting your balance to collections.

Patient: _____ E-mail Address_____

Name on Credit Card: _____

Card Type: (Visa) (Master Card) (American Express) (Discover) CVV/CID_____

Card Number_____ Exp .Date_____

The Billing Address of the Card_____City_____State____ zip_____

_____ _____
Signature Date