OFFICE POLICIES AND AGREEMENTS

All patients are required to read & initial each section, and sign twice below, before any services can be rendered.

Last Name: _____ First Name: _____ Middle Initial: _____

_____ **PRIVACY POLICY**

I have read and understand Eli Anker, M.D., P.C.'s "Notice of Privacy Practices" as mandated by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Copies of this notice can be found in the patient waiting room and a digital version is available at eliankermd.com.

_____ **VIDEO AND AUDIO RECORDING POLICY**

I understand that to ensure confidentiality and privacy, any type of electronic recording, using smartphones and/or similar devices is prohibited at any location within this office, during any part of my visit. Unauthorized recordings are a breach in the confidentiality rights of other patients and infringe on the privacy rights of the surgeons and their employees. I may take notes during important discussions and my visit will be fully documented in my medical chart.

_____ **FINANCIAL POLICY**

I understand that all patients must complete the "Patient Information" form before seeing the doctor/having my test and I agree to update this form periodically. It is my responsibility as the patient/insured to inform this office of any changes to insurance company/policy, policyholder relationship, address, and/or telephone numbers. A new form must be completed in these instances. I understand that failure to do so may delay processing of insurance claims and may increase the risk of denial of benefits by my insurance company.

_____ **Insurance**

Eli Anker, M.D., P.C. accepts insurance as payment for covered procedures, however, insurance is a contract between me and my insurance company. I understand that while Eli Anker, M.D., P.C. will gladly handle the paperwork and file my insurance claims, I, the patient/insured, am ultimately responsible for my bill. My secondary insurance will also be filed as a courtesy. In addition, I am responsible for any and all co-payments, deductibles, non-covered procedures, and/or if my insurance company deems a service as not medically necessary. Further, I understand that I am responsible for complying with the requirements that my insurance carrier may have regarding referrals, authorizations, covered/non-covered benefits, and second opinions.

_____ **Co-payments**

All co-payments are due at the time of service. I agree to pay prior to seeing the doctor/having my test.

_____ **Payments**

I acknowledge that Eli Anker, M.D., P.C. can accept cash, personal checks, MasterCard, Visa, and/or Discover but that form of payment will be at the office's discretion. All owed money is due one month after the final insurance payment is received by either the office or directly by me. I understand that if not paid, I may incur a late fee charge of $10/month, collection costs, and/or legal fees. Further, I agree to a $20 charge for any returned ("bounced") checks. I will forfeit all insurance checks I receive for any Date of Service (DOS) to Eli Anker, M.D., P.C. along with the Explanation of Benefits (EOB).

_____ **Out-of-Network**

I am aware that the individual physicians at Eli Anker, M.D., P.C. are not all participating providers in the same insurance plans (including Empire, GHI, and Cigna). However, they will gladly accept patients with these plans. I understand that for all insurance companies that Eli Anker, M.D., P.C. does not have a contractual agreement with, they will accept the "Out-of-Network" benefits, if such benefits are available, but I, the patient/insured, am responsible for knowing and understanding my specific policy, as benefits vary from plan to plan, and for any and all amount due in accordance with my Explanation of Benefits (EOB).

_____ **Referrals**

I understand that if my insurance company requires a primary care physician referral, insurance referral, and/or authorization, in order for me to receive services from Eli Anker, M.D., P.C., it is my responsibility, as the patient/insured, to ensure that referrals are current, correct, and presented prior to my scheduled appointment. If I have not obtained a valid referral and it has not been received before I leave this office, my insurance may deny my visit and I agree to be financially responsible for payment of all services rendered on the date(s) of service (DOS).
I acknowledge that Eli Anker, M.D., P.C. will use its best efforts to assist me in obtaining all the necessary paperwork.

I have read the above policies of Eli Anker, M.D., P.C. and/or they have been fully translated/explained to me, and I certify that I understand the contents of each policy and I agree to comply with these statements. Eli Anker, M.D., P.C. reserves the right to change these policies at any time. This agreement supersedes all other verbal agreements.

_____ _____

Patient Signature Date

ASSIGNMENT AND RELEASE

I hereby authorize payment directly to Eli Anker, M.D., P.C. for all insurance benefits otherwise payable to me for services rendered. I authorize Eli Anker, M.D., P.C. and/or any provider or supplier of services in this office to release the information required to secure the payment of benefits. I authorize the use of my signature below on all insurance submissions.

_____ _____

Patient Signature Date