Manhattan Endocrinologist, PLLC

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INSURANCE POLICY

We are pleased that you have entrusted our physicians with your healthcare. In doing so, you can be assured that we are committed to providing you with the best medical care possible. We also appreciate that healthcare coverage can be a complex world and recognize the need to establish a clear and concise financial policy that helps you understand your responsibilities as a patient. We will do our best to assist you with understanding your purpose treatment and in answering questions relating to your insurance.

As a policyholder of healthcare insurance, it is your responsibility to be an informed consumer. It is expected that you have an understanding of your policy coverage, including your financial responsibilities- co-payment amounts, any deductibles and coinsurances for both participating and non-participating providers and facilities; if your plan requires a referral and if pre-certifications necessary for certain procedure.

I fully understand that, even though I have referral authorization from my primary care physician, if any insurance carrier deems that the visit/procedure is cosmetic or not medically necessary, I will accept full responsibility for payment. In addition, should my carrier deny payment due to the fact that I have a pre-existing condition, I will accept full deductible and co-insurance(s), if applicable, which is the difference between the insurance carrier approved/allowed amount and the paid amount. Each individual has an annual deductible amount which must be satisfied prior to insurance benefits commencing. If my insurance carrier determines that the visit/procedure is deemed cosmetic or not medically necessary, I will accept full responsibility for payment. In conclusion, should my carrier deny payment due to the fact that I have pre-existing condition, I will accept full responsibility for payment.

If I have unknowingly provided the incorrect information, such as the primary carrier, effective date of coverage or I have not provided your office with necessary identification card and/or referral authorization at the time services are rendered, I agree to be fully responsible for the charges incurred. Furthermore, if it is ascertained that I am insured by a carrier of which you are not a participating provider, I understand that I will only be reimbursed the insurance payment issued and not the charges I have incurred and paid.

I authorize the release of any information necessary to process my insurance claim. I request the payment be made directly to the physician for services rendered. A copy of this authorization may be used in place of the original.