Vipul Patel, MD Phay Huynh, PA-C
Andrew Yang, MD Timothy Godfrey, PC-A

New York Hand Surgery
New York Hand Surgery of Queens
www.handsurgeon.com
Ph. 718-369-4263 Fax. 718-369-4265 Text. 917-473-9890
Brooklyn Office : 330 9th street Brooklyn, NY 11215
Queens Office : 54-07 Roosevelt Avenue Woodside, NY 11377

Date : ___________________________

Patient Financial Responsibilities

Co- Payment & Deductible

You are responsible for your deductible & co-payment. Your co-payment is due at the time of service. If your deductible has not been satisfied, payment may also be required at the time of service. Your signature below confirms you have been advised.

Non-Covered Services including DME (Durable Medical Equipment)

If Services provided are not covered by your health insurance carrier, you may be responsible for payment on those services. Your Signature below confirms you have been advised and also constitutes an agreement to pay for such services.

Out of Network Services

New York Hand Surgery, PC does not participate with **United Healthcare, The Empire Plan, Aetna, Cigna, Emblem, GHI and Oxford Insurance**. If you are covered by any of these plans, we do not have a contract with your health carriers. As a result, you may be financially responsible for a higher share of the fees, than a provider within your network. **YOU MAY ALSO RECEIVE THE CHECK DIRECTLY FORM YOUR CARRIER**, your signature below confirms you have been advised and constitutes an agreement to pay your portion of the out of network fees and release the issued check to New York Hand Surgery, PC.

Member Appeal Authorization

I hereby authorize New York Hand Surgery, PC and its agents to represent me, and act on my behalf regarding my medical health claim determination, in the event my claim is denied and/or if my claim is processed below my level of benefits.

I authorize my insurance carrier to release my protected health information to my representative for the purpose the appeal. I understand this information in privileged and confidential and will only be released as specified in this authorization or permitted by law.

This authorization will expire upon resolution of this appeal.

______________________________	______________________________	__________
Patient Signature or Legal Guardian	**Print Name**	**Date**
______________________________	______________________________	__________
Employee Signature	**Print Name**	**Date**

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MEMBER APPEAL REPRESENTATION AUTHORIZATION

I hereby authorize New York Hand Surgery Queens, PC and its agents to represent me, and act on my behalf regarding my medical health claim determination in the event my claim is denied and/or if my claim is processed below my lower level of benefits.

I authorize my insurance carrier to release my Protected Health Information to my representative for the purpose of resolving the appeal and understand this information is privileged and confidential and will only be released as specific in this authorization, or as required or permitted by law.

This authorization will expire upon resolution of the appeal.

______________________________ _______________
Patient's Signature or Legal Guardian Date

____
Print Name

______________________________ _______________
Witness Signature Date