WILLIAM G. PATRICK, M.D., P.C.
212 HIGHBRIDGE STREET, SUITE A
FAYETTEVILLE, N.Y. 13066

SIGNATURE ON FILE, INSURANCE AND PATIENT FINANCIAL POLICY

WE PARTICIPATE WITH THE FOLLOWING INSURANCE COMPANIES: **Medicare, POMCO, Excellus BlueCross BlueShield PPO (Not Healthy New York Prefix: VYH OR VYT), HMOBlue, Medicare BCBS PPO, Aetna, AetnaHMO, AetnaMedicare, Lifetime, United Healthcare (Not Empire United Healthcare or Community Plan)**

A No Show charge will be charged if you do not come for your appointment. Less than 24 hours notice in advance of your scheduled office appointment will have a $35 charge and a surgical appointment will have a $55 charge. Cancellation of Monday morning surgical appointments must be made by noon on the Friday prior.
There is a bank fee charge for which you are responsible if your check is returned for any reason.
Responsibility for all collection agency fees is yours if your account is unpaid.

RELEASE OF INFORMATION:

I authorize the release of Medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician. Any medical problems due to restraints placed by your insurance plan are not the liability of this practice.

Patient or Responsible Party Signature: ________________________________ Date _________________

PAYMENT POLICY FOR HMO, PPO, and other participating insurance patients:

You will be responsible for paying your deductible, copayment, coinsurance and charges for any non-covered cosmetic services. Referrals required by managed care insurance are the responsibility of the patient. If your referral is not obtained prior to your appointment you will need to reschedule your appointment.

Commercial or Self Pay Patients: **Patients who are not insured or are covered by private, commercial plans in which our physicians are not providers will be required to pay the office visit charge and any surgical charges at the time of service. Some surgical charges are dependant on the pathology diagnosis and will be billed to you after the charges are determined. The entire balance will be your responsibility. If you have a private or non participating insurance, reimbursement to you from your insurance carrier is your responsibility.**

Patient or Responsible Party Signature ________________________________ Date _________________

MEDICARE PATIENTS ONLY:

This office is required to keep you signature on file authorizing us to file claims for you and to release information to that payer if they require it to the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financial Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

Signature as it appears on Medicare Card: __________________________________ Date _____________

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services

Signature as it appears on Medicare Card: __________________________________ Date _____________