Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. **Our preferred method of payment is by credit or debit card**.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient Name: Huizi Bing	**Patient Signature:** 	**Date of Birth:** 01/19/1995
Patient Address: 235 west 48th st, Apt 27E	**City, State:** New York, NY	**Zip:** 10036
Today's Date: 07/16/2020		

Guarantor Name: (if not the patient)	**Guarantor relationship to patient:**	**Guarantor Signature:**

Mount Sinai

Department of Orthopedic Surgery

FINANCIAL WAIVER

Date: 07/16/2020

Patient Name: Huizi Bing

MRN (account number): _____

Physician: _____

Insurance Carrier: _____

This is to acknowledge that I am financially responsible for charges not covered by my insurance carrier due to the physician's non-participating/out-of-network status with my insurance carrier or due to a lack of referral or prior authorization required for today's services should one not be present at the time of service. I acknowledge I am financially responsible for charges for lack of insurance information necessary at the time of service. I acknowledge that I am financially responsible for any deductible, coinsurance, or co-payment as well as any non-covered charges deemed my responsibility by my insurance carrier.

Patient's Signature: _____ **Date:** _____

Patient's Name: _____ **Date:** _____

(Print Name)

How Do You Describe Yourself ?

Mount Sinai

We collect additional information on the background of all our patients. We would like you to tell us more about yourself so that we may review the treatment that all patients receive and make sure everyone gets the highest quality care. Your responses are not shared outside of the hospital and your information will remain private.

Please circle the options below which best describe you.

#1. WHAT IS YOUR RACE?

(Circle one or two options below. NOTE: If you select Asian, Black, or Native Hawaiian or Pacific Islander, see Question #1A to select your background.)

I	AMERICAN INDIAN OR ALASKA NATIVE
SEE BELOW	ASIAN
SEE BELOW	BLACK
SEE BELOW	NATIVE HAWAIIAN OR PACIFIC ISLANDER
W	WHITE
O	OTHER
U	UNKNOWN

#1A.WHAT IS YOUR BACKGROUND? (Select one or two options below)

ASIAN	
AA	Asian Indian
AB	Bangladeshi
AF	Chinese
AG	Filipino
AK	Japanese
AL	Korean
AM	Laotian
AZ	Pakistani
	Other_____

BLACK	
BA	African-American
BB	Barbadian
BD	Congolese
BJ	Ghanaian
BN	Haitian
BP	Jamaican
BT	Nigerian
BU	Senegalese
	Other _____

NATIVE HAWAIIAN OR PACIFIC ISLANDER	
PC	Chuukese
PE	Guamanian
PM	Native Hawaiian
PQ	Papua New Guinean
	Other _____

#2. ARE YOU SPANISH/HISPANIC/LATINO?

(Circle one option below. NOTE: If you select "I AM SPANISH/HISPANIC/LATINO", see Question #2A to select your background also.)

SEE BELOW	I AM SPANISH/HISPANIC/LATINO
N	I AM NOT SPANISH/HISPANIC/LATINO
U	I DO NOT KNOW

#2A. WHAT IS YOUR BACKGROUND?

SPANISH/HISPANIC/LATINO ORIGIN (Select one or two options below)	
2	Argentinean
14	Colombian
18	Dominican
19	Ecuadorian
22	Honduran
25	Mexican
33	Puerto Rican
34	Salvadoran
	Other _____

Data Form Version: December 5, 2018