New York Orthopedic Specialists, P.C. **(5)**
Scott V. Haig, MD Markella Kolitsopoulos, PA
700 White Plains Road, Suite #10
Scarsdale, NY 10583

OUR FINANCIAL POLICY

REFERRAL: If your insurance 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 visit. If you do not have your referral, and it is required, you will be responsible for your bill or your appointment will have to be rescheduled.

If you are completely certain that you DO NOT REQUIRE a referral from your insurance company and the claim is rejected for no referral you will then be held responsible for the visit

Wavier: I agree that it is my responsibility to make payments directly to NYOS should I fail to provide my insurance company's REQUIRED referral from my primary physician.

If your insurance is terminated or invalid at the time of your visit you will also be held responsible for the cost of your visit.

Copayments/Coinsurance/ Deductible- Your copayment is due at the time of your visit. We do not give courtesy to anyone. This is a contract between you and your health care carrier. Deductibles are billed.

- Please note, if you are having an X-RAY a separate copayment may apply.
- Some plans do deny certain screening, labs, tests, DME supplies or injections.
- Any purchases from or through the office or non-refundable.

Cancellation/ No Show: If you cancel your appointment less than 24 hours in advance a fee of $25 will apply. If you do not show up the same fee applies.

If this visit is related to a NO Fault accident or Workers Compensation case you should immediately inform the front desk. In order to be seen we require all information such as case or policy #, name and address of the carrier, date of injury, and name, number, and fax of the adjuster handling the case. If you fail to inform the staff of your visit being related to a No-Fault case or Workers Compensation case and later decide it is related we will absolutely not revised submitted/paid claims.

Please initial here: _____ to confirm you are not providing any NO-Fault or Workers Compensation information related to this visit.

_____

Print Name (if under 18 parent/legal guardian sign or health care proxy)

_____

Please sign (if under 18 parent/legal guardian sign or health care proxy)

_____

DATE