Patient Insurance Coverage Agreement

Date: _____

Dear _____

We have verified your commercial insurance and would like to make sure you fully understand your benefits. Please take a moment to review the following information:

1.) Plan Limitations:

_____ visits per condition per calendar year/lifetime.

_____ consecutive days per condition per calendar year/lifetime.

_____ visits based on medical necessity and subject to review.

_____ calendar year/contract year deductible. _____ due.

2.) Patient Co-payment of $_____ per visit.

We will bill your insurance carrier for your office visits. The co-payment is due either on a per visit basis or if you prefer, you may leave a credit card on file that will be billed monthly. Appointments not cancelled within 24 hours and missed appointments are subject to a $50.00 charge that is not billable to any insurance.

As an out of network provider reimbursement for care will go directly to you along with all relevant Explanation of Benefits (EOB) forms. A credit card on file is required. All checks and EOB's must be submitted to the office within 2 weeks of issue date or we reserve the right to bill your credit card **in full** for the visit reimbursed to you.

If you have any questions or concerns, please do not hesitate to contact our billing service at (212) 206-6465.

Thank you for your attention to this matter.

I have read and understood this agreement.

Patient Signature: _____ Date: _____