**Dr. Gregory A. Baum  Dr. Anthony R. Deboni**
Beth Phillips, PA

# CNY Cosmetic & Reconstructive Surgery, LLC

We welcome you to our practice and look forward to providing you medical care. Please do not hesitate to ask our staff if you have any questions.

## Please complete the enclosed patient information and medical history forms and bring them to your appointment.

**INSURANCES THAT REQUIRE REFERRALS**:

If your insurance requires a REFERRAL from your PRIMARY CARE PHYSICIAN (PCP), please obtain the REFERRAL and bring it with you to your first appointment. If you do not have your REFERRAL at the time of your first appointment, we will reschedule your appointment to help you avoid incurring an uncovered medical office visit charge.

**IF WE DO NOT PARTICIPATE WITH YOUR INSURANCE CARRIER**:

We will file the claim if you provide us with the following information: Name and mailing address of your insurance carrier, policy number, group number, policy holders' full name, policy holders' date of birth and social security number. We file these claims as a courtesy to you so that your insurance carrier reimburses you in a timely manner.

**CO-PAYS:**

If your insurance requires a patient co-pay, we will collect the co-pay at the time of check-in.

**IF YOU HAVE NO INSURANCE COVERAGE:**

Payment will be collected at the time of check-in. We accept cash, check, Visa, Mastercard and Discover cards.

**DISABILITY PAPERWORK:**

There will be a one-time $30.00 charge for the completion of disability paperwork. This fee is payable prior to the filing of the disability paperwork.

**CANCELLATIONS:**

Appointments need to be rescheduled or cancelled with ***24 hours notice.*** Your account be assessed a ***$50.00*** fee if this policy is not adhered to. This policy helps our practitioners be available to meet our patients' medical needs.

CNY Cosmetic & Reconstructive Surgery, LLC.
Dr. Gregory Baum/Dr. Anthony Deboni/Beth Phillips PA

# PATIENT INFORMATION

**New:** **Date:**_____ **Who may we share your medical information with:**_____

**Updated:** **Date:**_____ _____

**PLEASE REMEMBER TO BRING YOUR INSURANCE CARDS WITH YOU ON THE DAY OF YOUR APPOINTMENT.**

First Middle Last

Patient Name:_____Date of Birth:_____Age:_____

Street Address:_____SSN:_____

City:_____State:_____Zip:_____Home Phone #_____

Employer:_____Work Phone #_____Cell Phone #_____

**Email address**:_____

Primary Care MD:_____Address:_____Phone #_____

Referred by:_____

**Spouses' Information or Nearest Relative (Emergency Contact):**

Spouses' Name:_____Date of Birth:_____

Street Address:_____

City:_____State:_____Zip:_____Home Telephone:_____

Work Telephone:_____Cell Telephone:_____

**INSURANCE INFORMATION**

**PRIMARY INSURANCE NAME & ADDRESS:**_____

Subscriber Name & Address:_____DOB:_____

Subscriber Employer & Address:_____

ID#_____Group #_____

**SECONDARY INSURANCE NAME & ADDRESS:**_____

Subscriber Name & Address:_____DOB:_____

Subscriber Employer & Address:_____

ID#_____Group#_____

## ASSIGNMENT OF INSURANCE BENEFITS & AUTHORIZATION TO RELEASE INFORMATION

TO OUR ***MEDICARE PATIENTS***: PLEASE COMPLETE #1: STATEMENT OF AUTHORIZATION FOR PAYMENT OF MEDICARE BENEFITS.

WE ALSO NEED YOU TO COMPLETE NUMBER 2 AND NUMBER 3 BELOW.

1. I certify that the information by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration, or its carrier, any information about me to process my Medicare claim. I request that payment under the Medical Insurance Program be made to CNY Cosmetic & Reconstructive Surgeons, LLC for services rendered to me during the period of _____to life.

   Medical Beneficiary Signature_____Date:_____

   Medical Health Ins. Claim Number_____Effective Date:_____

**TO ALL OF OUR PATIENTS – COMPLETE NUMBER 2 AND NUMBER 3: ASSIGNMENT OF BENEFITS**

2. I hereby assign all medical and/or surgical benefits, to include major medical benefits, private insurance, and any other health plan to CNY Cosmetic & Reconstructive Surgeons, LLC. This assignment is to be considered as valid as an original. I understand that I am financially responsible for all changes whether or not paid or allowed by insurance. I hereby authorize said assignee to release all information necessary to secure payment. In the event my account is assigned for collection, I agree to pay all costs of collection including reasonable attorney fees and any future outstanding balances. I acknowledge that there will be a 1.5% finance charge on all balances over thirty (30) days.

   Signature:_____Date:_____

3. I understand and agree to pay for any service provided to me because it may not be a paid benefit under my health insurance policy and/or for one of the reasons outlined below. I further acknowledge that I am aware that I can be held personally responsible for payment of some or all medical expenses incurred for these services. I have been given the option of rescheduling my appointment for a later date if I elect not be been seen today.

   a. Prior authorization was not received for the Primary Care Provider, or

   b. I do not have health insurance coverage, or

   c. The service may not be deemed medically necessary, or

   d. The service is not a covered benefit under the terms of the contract, or

   e. Service(s) applied toward deductible or co-insurance.

   This waver will stay in effect until such time I terminate treatment with CNY Cosmetic & Reconstructive Surgeons, LLC. by written letter.

   *There will be a fee for appointments missed or cancelled with less than 24-hour notice.* Any checks sent back to CNY Cosmetic & Reconstructive Surgery, LLC for insufficient funds will incur an additional fee by me. I accept responsibility for co-pays and/or balances at the ***time of service***. I, the patient or guarantor, authorize CNY Cosmetic & Reconstructive Surgery, LLC. to call in prescriptions to my pharmacy, leave messages on my answering machine pertaining to appointments or billing issues & mail appointment cards to me. I authorize the release of medical information, including diagnosis, to my primary care physician/referring physician and any physician whom CNY Cosmetic & Reconstructive Surgery LLC may refer me to.

   Patient or Responsible Party Signature:_____Date:_____

   Patient or Responsible Party (Print)_____