Robert Bos, MD
515 Madison Ave, 6th Floor
New York, NY 10022

PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____

Insurance: _____

Effective Date: _____

Total Insurance Deductible: _____

Total Deductible Paid to Date: _____ as of _____/_____/_____ (date)

Total Remaining Deductible: _____

CoInsurance: __(e.g. 70/30) _____

CoInsurance payments: _____
(Coinsurance is the fee you pay after your deducible is met. We will try to estimate your financial responsibility at the time of your visit, but this may change depending on your insurance reimbursement. As such, you may receive a bill at a later date for the remaining balance.)

Fees for Dr. Bos' services are as follows:

Well Physical
Includes EKG, spirometry, hearing test, and blood draw

New/Established Patient	$450

Diagnostic/Treatment

Home visits	$600
Email/phone consultation	$100
New Patient Visit	$250
Follow-up	$125
Sick Visit – established	$150
Visa Examination	$350
Blood draw	$35
EKG	$100
Spirometry	$100
Hearing screening	$75
Echocardiogram	$500
PVR	$200
Carotid Ultrasound	$200
Chest X-Ray	$150
Sinus X-Ray	$100
All Immunizations	$75 - $200

I, _____, understand that I am responsible for the payment of the fees applicable for the services rendered by Dr. Bos at each appointment. I understand that fees for these services are subject to change and I will be notified of that prior to receiving treatment. I understand that the above listed fees are not exhaustive and that additional fees may be incurred, which I will be aware of prior to receiving treatment.

I understand that Dr. Bos does not accept all insurance plans and is out-of-network with all insurances accepted. Per your insurance carrier, as out-of-network providers, it is mandatory that we collect all deductibles and co-insurance as determined by your insurance plan. Your insurance plan is a contract between you and your insurance company, Dr. Bos is not party to that contract.

I understand that I am responsible for payment of the applicable deductible/co-insurance for serviced rendered by Dr. Bos and his associate(s). Out-of-network deductibles are due in full at the time of serviceA payment towards the co-insurance will be due at the time of service and I will be balance billed by Dr. Bos' office for any additional co-insurance amount owed to Dr. Bos.

I understand that some insurance do not allow out-of-network providers to be paid directly. I understand that should I receive payment from my insurance carrier for services rendered by Dr. Bos that I am responsible to provider either the endorsed insurance check payable to Dr. Bos or a personal payment payable to Dr. Bos in the same amount via cash, personal check or credit card. I will also provide all Explanation of Benefits (EOB's) from my insurance carrier with these payments.

_____

Name/Signature Date

I understand that should my insurance company deny any services provided, I will be responsible for the balance. I understand that I may have limited benefits and/or visits allowed with certain providers under my plan.

I understand that while the office staff will do its best to verify my out-of-network benefits, deductibles, co-insurance and track the number of visits allowable under my plan as applicable, it is ultimately my responsibility to verify my benefits and track the use of these benefits under my plan. Further, I understand that if I exceed the number of allowable visits, I may be financially responsible for any visits and services rendered that are not covered by my insurance plan. I will promptly provide the office with any changes in my existing insurance coverage.

In some cases, patients may choose to receive services that are not covered by insurance, and are financially responsible to pay for such services as will be discussed prior to receiving those services.

I understand that I am responsible for providing Dr. Bos' office with up-to-date insurance information and appropriate referrals, if required by my insurance plan.

_____

Patient Print Name

_____

Signature Date

FOR OFFICE USE ONLY

I _____ (staff member) have discussed the financial responsibilities with the above listed patient and he/she understands Dr. Bos' policies as outlined in this form.

_____

Staff Member Print Name

_____

Signature Date