Robert Bos, MD
515 Madison Avenue, 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 deductible 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	$450.00

Diagnostic/Treatment

Home visits	$600.00
Email/phone consultation	$100.00
New Patient Visit	~~$225.00~~ 250
Follow-Up	$125.00
Sick Visit – Established	$150.00
Visa Examination	$350.00
Blood draw	$35.00
EKG	$100.00
Spirometry	$100.00
Hearing Screening	$75.00
Echocardiogram	$500.00
PVR	$200.00
Carotid Ultrasound	$200.00
Chest X-Ray	$150.00
Sinus X-Ray	$100.00
All Immunizations	$75.00-$200.00

I, _____, understand that I am responsible for payment of the fees applicable for the services rendered by Dr. Bos at each appointment. I understand that the 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