New York Medicine Doctors

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PATIENT TREATMENT AGREEMENT AND FINANCIAL DISCLOSURE

Thank you for choosing Advanced Physicians, P.C. (the "Practice") to assist you with your medical needs. This is our Patient Agreement and Financial Disclosure, which will specify our agreement with you regarding the treatment we provide. Please review the provisions below, and let our staff know if you have any questions.

1. CONSENT TO MEDICAL CARE: By my signature or electronic signature below, I hereby request and authorize the physicians and other healthcare providers of the Practice and their professional staff, to perform any medical diagnostic procedures and medical or surgical care which in their professional judgment is deemed necessary to diagnose and/or treat the conditions(s) that have brought about my seeking medical care services at the offices of the Practice. **I understand that the practice of medicine is not an exact science, and that there are risks and benefits associated with receiving medical treatment. I acknowledge and agree that no guarantees are made to me concerning the results and outcomes of the medical examination and treatment rendered by the physicians and professional staff of the Practice.** I further acknowledge that the Practice may, in its sole discretion, discharge me as a patient at any time for any reason or no reason, and that at such time as I am discharged, my medical records will be made available to me or shall be transferred to another provider at my request. I understand that if I have any questions or concerns regarding any aspect of treatment, I may ask my treating provider at any time.

2. RELEASE OF MEDICAL RECORD INFORMATION: I hereby authorize the Practice to disclose all or any part or the contents of my medical record to such insurance companies, organizations, or agencies that may be concerned with the payment of medical services rendered to the registered patient(s) consistent with Federal and State privacy laws regarding medical records. This authorization is given with full knowledge and understanding that such disclosure may contain information which may result in a valid denial of insurance benefits, or which otherwise may not serve the interests of the registered patient(s) or myself.

3. ASSIGNMENT OF INSURANCE BENEFITS: I hereby request and authorize that any and all insurance benefits due and payable for medical services rendered to me by the Practice be paid directly to the Practice.

4. PRIVACY POLICY ACKNOWLEDGMENT: I acknowledge that I have received a copy of the Notice of Privacy Practice for the Practice.

5. FINANCIAL AGREEMENT AND GUARANTEE: I accept full and complete financial responsibility for all medical services rendered and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make such payments in accordance with the payment policies of the Practice, or in the event of default of my financial obligation to pay for services rendered, the Practice may terminate the "doctor-patient" relationship me in accordance with the laws of New York. Furthermore, in the event of my default of my financial obligation, should my account be turned over to an external collection agency for non-payment, I agree to pay any associated collection costs. I understand that in the event the services rendered are not covered by a medical insurance plan, I will be required to make a payment deposit of 50% of the estimated cost at the time of visit before any medical care will be rendered. I understand that the payment of the deposit represents only a partial payment of the total fees that may be charged for the medical service to be rendered, and that I will receive a statement for the total charges incurred. I understand that this balance must be paid in full at or before the next visit.

In the event I choose to pay my outstanding bills via check and my check is returned by the bank for insufficient funds (i.e. "bounces"), I understand I am responsible for making payment in full and for any associated bank fees incurred by the Practice.

If an account is sent to an attorney for collection, I agree to pay all collection expenses, court filing fees and reasonable attorneys' fees as established by the court. If my account is delinquent, I may be charged a service fee.

By signing this form, I agree to the above stated terms and conditions regarding the services I will receive from Advanced Physicians P.C.

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Name of Patient

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Signature of Patient (or guardian)

_____

Date