North Suffolk Endocrinology, PC
Joseph C. Terrana, MD, FACE
Financial Policy

Thank you for choosing Joseph C. Terrana, MD, FACE as your healthcare provider.
The following is a statement of our financial policy. Please read and sign below prior to service.

Patients with participating insurance coverage:
All co-payments, deductibles, co-insurances, referrals and/or pre-certification/authorization numbers are expected at the time of service or prior to it. If your insurance coverage has been denied or terminated, you agree to be responsible for payment in full. Co-pays not paid at the time of visit are subject to a $10.00 billing fee.

Patients with Medicare and no secondary insurance coverage:
You are responsible for meeting your annual Medicare deductible. If the deductible has not been met at the time of your visit, you will be charged the appropriate amount at the time of your appointment. Once your deductible has been met, the Medicare 20% co-insurance will be due at the time of your visit.

Patients with non-participating insurance coverage:
Your insurance policy is a contract between you and your insurance company. As a medical care provider, our primary relationship is with you, not your insurance company. We may choose to accept assignment of benefits upon verification of your insurance coverage and submit the billing to your insurance company on your behalf. In that case, if full payment is not received within 45 days, you will be held responsible for the balance. Please be aware that some, perhaps all, of the indicated services may be considered non-covered services and/or not considered reasonable and necessary under the terms of your policy/carrier.

Our practice is committed to providing the best service for our patients and charges what is usual and customary for our area. If we do not participate with your insurance company, payment in full is expected regardless of your insurance company's determination of usual and customary rates.

Returned checks will be subject to an additional $30 collection fee.
If you experience extenuating circumstances, payment arrangements can be made through our Practice Administrator.
We request a $0.75 per page charge for all copies of medical records.
We reserve the right to impose a $25 fee for missed appointments/cancellations within 24 hours of the visit. This charge is not covered by your insurance carrier.

I authorize and assign any payment of medical benefits to North Suffolk Endocrinology, PC, its successors and assigns. I also agree to pay interest at the prevailing rate for amounts 30 days past due, as well as all costs including legal fees associated with the collection of any amounts due for services rendered. I agree to notify Dr. Terrana's office of any change regarding my health insurance status. I acknowledge that I will be responsible for all unpaid claims if I fail to provide insurance information within my health plan's filing limit for services rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please feel free to contact us.

I have read and understand all of the above information. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account.

_____ _____
Patient Signature Date

AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS
----------TO BE SIGNED BY ALL PATIENTS----------

I authorize the release of my medical information for purposes of treatment, payment, and healthcare operations to all healthcare facilities and providers involved in my care. I authorize any holder of my medical information to release to my insurance company/the Centers for Medicare and Medicaid Services and its agents any information needed to determine benefits for related services rendered.

_____ _____
Patient Signature Date