



Able Orthopedic & Sports Medicine, PC

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PATIENT ACKNOWLEDGEMENT OF THE NOTICE OF PHYSICIANS AS NON-PARTICIPATING PROVIDER

I acknowledge that I was provided with a copy of the Able Orthopedics and Sports Medicine Notice of Physician as non-participating provider of my medical insurance.

I verify the accuracy of the information of this form. I hereby authorize direct payment of surgical/medical benefits to my physician, for services rendered by him/her in person or under his/her supervision if I have not paid in advance. I understand that I am financially responsible for all services. Additionally, I will work with the doctor's office to have Compensation and No Fault claims paid to the doctor, and I understand that all bills are my responsibility if not paid by the carrier.

AOSM will provide you a receipt so you can file the claim with your insurance company. In addition, I understand that I am responsible of obtaining referral authorization from my primary care physician if needed. Paying my deductible, co-pay, coinsurance and any services that are not covered by my plan, at the time of my visit.

I hereby authorize my physician, to release any Medical or Incidental Information that may be necessary for either medical care or in processing applications for financial benefits.

I have read, understand and agree to this Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-payment and deductible are my responsibility and are payable immediately upon receipt of patient statement of account.

I authorize my insurance benefits be paid directly to the Able Orthopedics and Sports Medicine.

Patient Signature: _____ **Date:** _____