



Plastic Surgeons of the Hudson Valley

Board Certified Plastic Surgeons

- Lawrence Enisman MD FACS
- Michael Freedman MD
- Celestino Sepulveda MD

POLICY INFORMATION

Our goal is to give each patient the care he/she needs within their appointment time. If extended care is needed or emergencies arise, we ask that you please be patient knowing that when you are with the doctor, you will also be afforded all the time necessary for your care.

Plans that we participate with are:

Aetna	Blue Cross Blue Shield	CDPHP	Emblem Health/GHI
The Empire Plan	HealthQuest	Hudson Health Plan	Medicare
MVP	No Fault	Oxford	United Healthcare
Workers' Compensation			

Insurance cards cannot be altered in any way.

If your insurance requires a referral, it is your responsibility to make sure that your doctor has sent the referral prior to your appointment, or you will be responsible for the cost of your appointment at the time of service.

If we do not participate with your insurance, we require payment on services rendered. All claims will be submitted to you insurance company for you. You will be responsible for the unpaid balance. We will be happy to appeal the claim ONCE. If denied we will give you any information you need to appeal the claim upon request.

Cosmetic surgical fees will be discussed with you at the time of your visit.

Medicare patients that do not have a secondary insurance to cover copayments, coinsurances or Medicare's yearly deductible, will be required to pay 20% of the charges for the visit and/or office procedures.

All copays, coinsurances and deductibles are due at the time of service. A \$5.00 will be assessed for each unpaid date of service. A monthly \$10.00 fee will be applied to any unpaid balance over sixty (60) days.

A \$25.00 fee will be assessed if you do not cancel your scheduled appointment at least 24 hours in advance.

Workers' Compensation and No Fault patients must have insurance information so that we can submit all of the necessary paperwork. It is your responsibility to supply us with all the correct information, including the insurance company, claim number, accident date, and a contact name and number. Failure to give us the information in a timely manner (45 days) will result in the patient being billed the full amount of services rendered. **Motorcycle accidents are not covered by No Fault.**

If you are victim of a crime and you have insurance, your health insurance is primary. Be sure you report the crime to the police. You may be able to obtain assistant from the New York State Crime Victim's Board. Please ask if you would like more information on Crime Victims.

If we are required to take legal action to collect payment, you will be responsible for any and all fees associated with such action, including filing fees, attorney's fees and collections fees.

Please let us know if you have any questions or would like a copy of this form for your records. Thank you.

Signature

Name

Date

207 Washington St. Poughkeepsie, NY 12601

Phone: 845 471-0800 Fax: 845 471-0811

WWW.plasticsurgeonsofthehudsonvalley.com

**PLASTIC SURGEONS OF THE HUDSON VALLEY
PATIENT INFORMATION**

Patient Name _____
Last First M.I.

Address _____
Street City State Zip Code

Phone _____ Cell _____

Email Address: _____
If you supply us with your email address, you are giving our office permission to email you directly.

Social Security No. _____ - _____ - _____ Marital Status _____

Age _____ M F Date of Birth _____

Spouse's Name _____ Phone _____

Insured's Social Security No. _____ - _____ - _____ Insured's D.O.B. _____

If patient is less than 18 years of age:

Parent/Guardian _____ D.O.B. _____

EMPLOYMENT INFORMATION

Your Employer _____ Phone _____

Address _____
Street City State Zip Code

Spouse's Employer _____ Phone _____

Address _____
Street City State Zip Code

DEMOGRAPHIC INFORMATION

Preferred Language: English Spanish Other: _____

Race: White
 Black/African American
 American Indian/Alaska Native
 Asian
 Native Hawaiian/Pacific Islander
 Other
 Patient Declined/Unknown

Ethnicity: Spanish/Hispanic Origin
 Not of Spanish/Hispanic Origin
 Patient Declined/Unknown

**Please bring your insurance card and driver's license to the window with your paperwork.
Thank you.**

INSURANCE INFORMATION

This section must be completed. The copy of your insurance card if for verification purposes only.

1. Primary Insurance Company _____

Address _____
Street City State Zip Code

Group No. _____ Policy No. _____

2. Secondary Insurance Company _____

Address _____
Street City State Zip Code

Group No. _____ Policy No. _____

PATIENT AUTHORIZATION

I hereby authorize the release of any medical and/or insurance information necessary to process any claims for services rendered by Plastic Surgeons of the Hudson Valley.

I hereby authorize the payment of my aforementioned medical benefits to the physician rendering services to me.

I further authorize the payment of my aforementioned secondary and/or Medigap medical benefits to the physician rendering services to me.

I have read the Policy Information Form which was given to me. I understand that I am ultimately responsible for any charges regardless of my insurance. Plastic Surgeons of the Hudson Valley will make all reasonable attempts to obtain payment from my insurance company. However, if these attempts fail, I understand that I will be am responsible for the charges.

Patient/Guardian Signature

Date