Dr. Alexander Raskin, Inc.: SERVICE and FINANCIAL AGREEMENT

PAYMENT FOR SERVICES:
Except as noted below, payments are due in full at the time of service. Our Financial Department and Front Office staff is here to assist you; however, it is your responsibility to be aware of your health insurance benefits and how to obtain them. Please inform the staff if preauthorization is required by your insurance. HMO patients are required to have all services and office visits preauthorized before scheduling appointments. Please notify us of any changes in your contact information or insurance coverage.

HOSPITAL PROCEDURE/SURGERY:
We will attempt to pre-authorize all surgeries and/or procedures with your insurance company. Professional fees for the doctor are due and payable to Dr. Alexander Raskin, Inc at time of your pre-operative visit. You should also expect to receive a bill from the hospital and anesthesiologist.

MEDICAL RECORDS TRANSFERS:
Any requested copies of your medical records require a signed release form. A fee to cover processing costs is due prior to release of records.

METHODS OF PAYMENT:
For your convenience, we accept personal checks (U.S. dollars), cashier checks, MasterCard, Visa, Discover, and American Express. A $25.00 bank fee is charged on all returned checks and any nonpayment orders.

RELEASE OF INFORMATION:
Dr. Alexander Raskin, Inc may disclose all or any part of your medical records and/or financial ledger, to any person or corporation (1) which is or may be liable under contract to Dr. Alexander Raskin, Inc for reimbursement for services rendered, and (2) any healthcare provider for continued patient care.

MEDICAL CONSENT:
I consent to routine evaluation and treatment under general and specific instructions of Dr. Alexander Raskin. I also, if necessary, agree to emergency treatment and/or transport to the nearest available hospital. I reserve the right to refuse specific services at anytime.

Initials: _____ I hereby authorize and give consent to routine evaluation and treatment to my daughter/son, and/or dependent under the general and specific instructions of Dr. Alexander Raskin, Inc. I also, if necessary, agree to emergency treatment and/or transport to the nearest available hospital/surgery center. I reserve, as guardian or legal representative to my daughter/son, and/or dependent, the right to refuse specific services at anytime. Services may include but are not limited to medical evaluation, casting, casting with manipulation, bracing (DME), injections, x-rays, and MRI's.

FINANCIAL RESPONSIBILITY:
I have read and understand the above statements. I accept full financial responsibility for my treatment. If my account becomes delinquent and is referred to a collection agency or attorney, I agree to pay all collection expenses, attorney and court costs. I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I acknowledge that if my child/dependent is cared for by Dr. Alexander Raskin, Inc that I will be responsible for the payment of services provided under the same terms and conditions.

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DIVORCED PARENTS:
We do not second party bill. The parent bringing the child to our facility is responsible to pay for required co-payments, deductibles, etc. at the time services are rendered.

Initials: _____ HMO or OTHER CONTRACTED PATIENTS:
For authorized covered services, I agree to pay Dr. Alexander Raskin, Inc. my portion of charges for the requested services and understand that the exact amount of my obligation may not be known to me until after my healthcare plan has processed the claim. Dr. Alexander Raskin, Inc. may bill my insurance and receive payment for services provided to me under the provisions of my plan's contract with Dr. Alexander Raskin, Inc. For services not covered by my insurance (authorization denied), I agree and understand that I may be asked pay the full amount of Dr. Alexander Raskin, Inc.'s standard fee for the services provided at the time of service.

Initials: _____ PATIENTS WITH NON-CONTRACTED HEALTH PLANS:
I authorize Dr. Alexander Raskin, Inc. to bill my insurance. I understand that any pre-determination of benefits by my insurance company is an estimate and the actual benefit payment will not be determined until the claim is processed. I agree to pay Dr. Alexander Raskin, Inc. in full for all services provided to me regardless of the amount reimbursed to me by my insurance company. I am responsible for paying any of the charges outstanding after 60 days.

The assignment/financial agreement will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original.

_____ _____
Signature of Patient and/or Legal Representative Relationship to Patient

_____ _____
Print Name Date

_____ _____
Witness Signature Date

** If an authorization is signed by an individual's personal representative, the representative's authority is based on:

_____(e.g. state law, court order, etc)