SUFFOLK PULMONARY ASSOCIATES, L.L.P.
SUFFOLK CRITICAL CARE ASSOCIATES, L.L.P
60 North Country Road - Suite 203
Port Jefferson, NY 11777

Patient Name: _____ Date of Birth: _____

Statement of Patient Financial Responsibility

Suffolk Pulmonary Associates, L.L.P. and Suffolk Critical Care Associates, L.L.P. appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The services you have elected to participate in, implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will bill your insurance carrier/carriers on your behalf. However, you are ultimately responsible for payment in full of your bill.

Many insurance companies have additional stipulations that may affect your coverage. It is ultimately the patient's responsibility to know your coverage and benefits. By signing below, you authorize Suffolk Pulmonary Associates, L.L.P. and Suffolk Critical Care Associates, L.L.P. to furnish information to insurance carriers concerning your care. You are responsible for any amounts not covered by your insurance. If your insurance carrier denies any or part of your claim, or if you elect to continue services past your coverage/policy period, you will be responsible for your balance in full. It is the patient's responsibility to obtain referrals or authorizations required by the insurance carrier to be seen at Suffolk Pulmonary Associates. Full payment for services provided by Suffolk Pulmonary Associates is due at the time of services rendered; fees and interest may be charged.

If payment is denied for lack of authorization, the patient understands that they are responsible for payment in full. You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at the time of service. Some health insurance carriers require the patient to pay a copay for services rendered. This is a contract between you and your insurance carrier. Payment of all copays is expected at the time the service is rendered to patients.

I understand that I am responsible for co-payments and deductibles or co-insurance, as dictated by my insurance carrier.

Initial _____

I fully understand that I am ultimately responsible for any and all charges associated with my account and that if I fail to pay any amount due, I will also be responsible for all late fees, collection fees, court costs, attorney fees and any other charges incurred in the collection of any balance due. I further understand that a collection fee of 30% will be added to the outstanding balance should my account be placed in collection.

Initial _____

Statement of Patient Financial Responsibility – Page 2

I have read the above policy regarding my financial responsibility to Suffolk Pulmonary Associates/Suffolk Critical Care Associates, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Suffolk Pulmonary Associates, L.L.P./Suffolk Critical Care Associates, L.L.P. I understand that any amount remaining after such payment has been made by my insurance carrier becomes the patient's responsibility.

_____ _____

(Signature of patient OR parent/guardian if patient is under the age of 18)

(Date)