

NEW ENGLAND ORTHOPAEDIC & SPINE SURGERY, LLC

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OFFICE POLICY

-Co-payments are expected at time of service unless other arrangements have been made with this office. Please refer to our patient information brochure for details regarding specific payment policies. Please be advised that we accept CASH, CHECK, MASTERCARD AND VISA

-If your insurer requires a referral, we must verify that at the time of service, a valid referral is on file with your insurer. It is the responsibility of the patient to notify PCP's that they are seeking treatment with our physicians and thus verify that referrals are on file prior to service date. Written verification of a valid referral is required at time of service, otherwise a waiver is signed and patients are responsible for following up on the referral.

-Prescription requests are accepted by mail and we ask you put your request for medication in writing along with a self-addressed stamped envelope. Please remember to calculate enough time for your requested prescription to allow for mailing both to and from our office. In most cases, we recommend that you send your request two weeks in advance. In the event of an EMERGENCY, prescription requests will be accepted during regular office hours via telephone.

-Twenty four hour notice of cancellation is requested if a patient is unable to keep an appointment. After two successive no-show appointments, further appointments will not be scheduled.

-Children under the age of eighteen must be accompanied by an adult.

AUTHORIZATION AND CONSENT

I request that payment under the medical insurance program to be made directly **to New England Orthopaedic & Spine Surgery, LLC.**

I hereby authorize New England Orthopaedic & Spine Surgery, LLC to furnish information to my insurance carrier (s), or its intermediaries in order to process claims.

If services being rendered pertain to a workers compensation injury, I authorize New England Orthopaedic & Spine Surgery, LLC to furnish information to my employer, insurer or its intermediaries in order to process claims.

I also understand that I am financially responsible for charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

Patient Name _____ Date _____

Signature _____