Scott J. Ratner, M.D., F.A.C.C., P.C.
407 Franklin Avenue Franklin Square, NY 11010

Dear Patient,

We appreciate your confidence in choosing our office for your medical needs. Please take a few moments to review our financial policy. Our interest is in assisting you in restoring your health and allowing you to maintain it. We render service(s) which are medically necessary, reasonable, and proper. However, some insurers have policies that may not reimburse for such services. We will assist you with any claim problems as best as we can, but ultimately you are responsible for services not covered by your policy.

AUTHORIZATION TO PAY*: I authorize that payment of medical benefits be made on my behalf to Scott J. Ratner, M.D., F.A.C.C., P.C. for any service(s) rendered.*

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: *I authorize any holder of medical information, regarding me, to release said information to my insurance company and its agents.*

INSURANCE RESPONSIBILTY: *Scott J. Ratner, M.D., F.A.C.C., P.C. has informed me that I am responsible for providing the office with accurate insurance information and for obtaining any referral needed from my Primary Care Physician.*

I permit a copy of this authorization to be used in place of the original. This authorization will remain in force until termination is requested in writing by the enrollee.

I understand that payment is due when services are rendered unless prior arrangements are made. Scott J. Ratner, M.D., F.A.C.C., P.C. will act as an agent in helping me obtain reimbursement from my insurance company. I understand that I am financially responsible for any copayment(s), coinsurance, deductibles, non-covered services, etc. stated by my insurance plan.

I have read the above and understand my obligations.

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Patient's Signature

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Today's Date