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NEW YORK PAIN CARE - PATIENT AGREEMENT FORM

Amr Hosny, MD, Josephine Musto, NP-C

THANK YOU for selecting the Pain Management Physicians working at New York Pain Care.

In order to facilitate your treatment here we ask that you read and sign this agreement and authorizations.

If you have any questions, please do not hesitate to ask for clarification.

- A scheduled appointment must be cancelled at least 24 hours in advance; otherwise a \$30.00 cancellation fee will be assessed. Additionally, all patients who do not show for appointments WITHOUT CANCELLING IN ADVANCE will be charged a \$50.00 fee.
- Fees due to New York Pain Care, PC for: Patient co-payment(s), deductible(s), cancellation fees, and treatments or fees not covered by a pre-approved medical insurance plan are to be paid prior to treatment.
- We will bill your insurance carrier as a convenience to you, however, if your carrier reimburses you, you agree to inform us of the receipt and to pay us promptly.
- If your care is not covered by insurance, you agree to be responsible for payment of all fees in full.

CONSENT FOR MEDICAL TREATMENT

I hereby authorize and request New York Pain Care, PC to provide such medical care and administer such diagnostic and/or therapeutic procedures and treatments as in the judgment of the physician in attendance are deemed necessary and advisable. I understand that I am entering into a contractual relationship with New York Pain Care, PC and the Physician for professional care. I further understand that meritless and frivolous claims for medical malpractice have an adverse effect upon the cost and availability of medical care, and may result in irreparable harm to a medical provider. As additional consideration for professional care provided to me by New York Pain Care, PC and the Physician, I and/or my representative agree not to advance, directly or indirectly, any false, meritless, and/or frivolous claim(s) of medical malpractice against New York Pain care, PC and the Physician.

Furthermore, should a meritorious medical malpractice case or cause of action be initiated or pursued, I and/or my representative agree to use ABMS board-certified expert medical witness(es) in the same or similar specialty as the Physician. Furthermore, I agree that these expert witnesses will adhere(s) to the guidelines and/or code of conduct defined by the specialty society(ies) for expert witnesses in the area(s) of medicine that would typically have the background and experience to opine on such a case.

Finally, you (the patient) agree that counsel for the Physician shall have the right and be free to depose such expert witnesses at least 120 days before any scheduled trial date. In consideration for this, I (the Physician) agree to the same stipulations.

Insurance Company

Signature of Patient or Authorized Representative

Relationship

Date

Physician

AUTHORIZATION FOR RELEASE OF INFORMATION FOR INSURANCE BENEFITS

I hereby authorize and direct New York Pain Care, PC, having treated me, to release to government agencies, insurance carriers, or others, who are financially liable for my care, all information needed to substantiate payment for my care and to permit representatives thereof to examine and make copies of all records relating to such care and treatment.

Insurance Company

Signature of Patient or Authorized Representative

Relationship

Date

ASSIGNMENT OF BENEFITS

I hereby assign, transfer, and set over to New York Pain care, PC and the Physician responsible for my treatment sufficient monies and/or benefits to which I may be entitled from government agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent. I understand that I am financially responsible for the charges not covered by my insurance. A Photostatted copy of this authorization shall be considered as effective and valid as the original. When signed by a Medicare recipient, this is a lifetime care authorization. This authorization may be revoked by either myself or the above named carrier at anytime in writing.

Insurance Company

Signature of Patient or Authorized Representative

Relationship

Date