Andrew D. Pearle, MD
Orthopaedic Surgery & Sports Medicine
535 East 70th Street
New York, NY 10021
Tel (212) 774-2878
Fax (212) 774-2798
www.andrewpearle.com

ASSIGNMENT AND RELEASE OF BENEFITS

I certify that the information given by me is correct. I understand that this information is entered into a database, and I authorize the sharing of information with affiliated physicians who are responsible for my care. I hereby also authorize the release of information related to my medical condition, as requested by government agencies and/or insurance carriers. I hereby assign my insurance benefits to Andrew Pearle, MD PC and understand that, in the absence of accepted insurance coverage, my legal guardian or I, am responsible for full payment of services rendered.

INSURANCE AND FINANCIAL RESPONSIBILITY

We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment for professional services. Our office participates with a variety of insurance plans. It is your responsibility to:

- **Bring your insurance card(s) to every visit**
- **Be prepared to pay your copay at each visit**
- **Make payment in full at the time of visit for medical care not covered by your insurance**
  - Payment can be made by Cash, Check, or Credit Card (we accept *Visa, Amex, Mastercard*)
- **Obtain and bring any required referrals for Specialist Visit(s) per your insurance plan. Failure to do so may cause you to be financially responsible.**
- **If you have insurance that we do not participate with, we will submit the claim to your plan's out-of-network benefits.**
- Your insurance carrier writes and administers your policy. We are happy to answer any insurance questions you have, but specific coverage issues and plan requirement questions should be directed to your insurance carrier.

MEDICARE PATIENTS

I understand that Andrew Pearle, MD PC has Opted Out of Medicare, and all services provided by the practice are self-pay services. (Please see attached form which provides further explanation)

EFFECTIVE DATE

These statements shall be effective from the date of the signature below until my insurance changes, at which time I understand that I am obligated to notify the practice.

_____ _____

Patient Name (Print) / DOB **Parent/Guardian Name if applicable (Print)**

_____ _____

Patient or Parent/Guardian Signature **Date**

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FINANCIAL AGREEMENT

The fee for surgery is determined not only by its complexity, but also by Dr. Andrew D. Pearle's particular expertise in Orthopedic Surgery & Sports Medicine. Although the vast majority of insurance companies accept Dr. Andrew Pearle's fees as appropriate and are aware that he is a recognized expert in the specialty, we cannot provide assurance that your particular insurance policy will consider his fee as "usual, customary, or reasonable".

In general, we will bill the insurance carrier directly for surgical services within one week of your operation (In most cases, we must wait for the operative report before sending). Once we have received their payment determination for the above, you will be billed for the balance of our "reasonable and customary" fee. For example, if you have an 80% usual and customary policy with your insurance, your out-of-pocket expense will be 20% of our fee, payable immediately after surgery. With a 100% usual and customary major medical policy, a substantial portion, and in many cases, the entire surgical bill is covered.

I also understand that if Dr. Pearle is a participating doctor in my insurance care plan, I am responsible for payment of any fees as determined by the contract of the insurance care plan.

I have been informed and understand that Andrew D. Pearle, MD works with a group of Physician Assistants (PA) who may assist in surgical cases in which an HSS resident is unavailable for your procedure. Please be aware that these PAs are out-of-network/non-participating with your insurance. Since the PAs are non-participating providers, receiving medical services from them may result in additional costs to you that are not covered by your health plan and that you will be responsible for these additional costs. The Patient and/or the Patient's Legal Guardian do hereby expressly consent to the patient receiving services provided by these PAs in the event that a HSS resident is unavailable at the time of the procedure and it is necessary that a PA assists during the surgical procedure. The Patient/Guardian understands that they are responsible for any deductibles, coinsurance, or any other balances deemed to be the patient's responsibility per your insurance plan. Additionally, Patients must return any claim checks they receive from their insurance company to Dr. Andrew D. Pearle's practice within 10 days of receipt to avoid collections.

Finally, I understand that I am ***directly responsible*** for the payment of my bill, regardless of third-party reimbursements. I understand also that the fee does not include any extraordinary services, nor hospital or anesthesia services. Hospitals, anesthesiologists, medical and other consultants all bill separately for their efforts on your behalf.

I authorize payment of my medical benefits directly to Andrew D Pearle, M.D.

FOR OUT OF NEW YORK STATE CAR ACCIDENTS AND JOB-RELATED INJURIES:

I understand that my insurance carrier will NOT pay my bills in full. I am directly responsible for any outstanding balance which my accident insurance and private insurance do not pay.

_____	_____
Patient Name (Print) / DOB	**Guardian/Guarantor Name (Print)**
_____	_____
Guardian/Guarantor Signature	**Date**

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***** PTS. WITH MEDICARE PART B *** PTS. WITH MEDICARE PART B *** PTS. WITH MEDICARE PART B *****

This agreement is between Dr. Andrew D. Pearle, whose principal place of business is 541 E. 71st Street, NY, NY 10021 and 1133 Westchester Ave, White Plains, NY 10605, and the Patient who is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Patient that Physician has opted out of the Medicare program effective on 9/22/2014 (to present date), and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Physician agrees to provide the medical services to Patient: office visits, surgery

In exchange for the Services, the Patient agrees to make payments to Physician directly at the time services are rendered. Patient also agrees, understands and expressly acknowledges the following:

- Patient agrees not to submit a claim (or to request that Physician submit a claim) to the Medicare program with respect to the Services, even if covered by Medicare Part B.
- Patient is not currently in an emergency or urgent health care situation.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for the Services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the Services because payment is not made under the Medicare program, and other supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he has a right, as a Medicare beneficiary, to obtain Medicare-covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted-out.
- Patient agrees to be responsible, whether through insurance or otherwise, to make payment in full for the Services, and acknowledges that Physician will not submit a Medicare claim for the Services and that no Medicare reimbursement will be provided.
- Patient understands that Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there were no private contract and a proper Medicare claim were submitted.
- Patient acknowledges that a copy of this contract has been made available to him.
- Patient agrees to reimburse Physician for any costs and reasonable attorneys' fees that result from violation of this Agreement by Patient or his beneficiaries.]

_____ _____

Patient Name (Print) / DOB **Parent/Guardian Name if applicable (Print)**

_____ _____

Patient or Parent/Guardian Signature **Date**

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ACKNOWLEDGEMENT AND CONSENT

Respect for our patients' privacy has long been highly valued at Hospital for Special Surgery. Not only is it what our patients expect, it is the right way to conduct health care. As required by law, we will protect the privacy of health information that may reveal your identity and provide you with a copy of our Notice of Privacy Practices that describes the health information privacy practices of our Hospital and its medical staff and affiliated health care providers when providing health care services for our Hospital. Our Notice will be posted in the main entrance area of the Hospital at 535 East 70th Street, New York, NY and in other locations where we provide services. You will also be able to obtain your own copy of the Notice by accessing our website at www.hss.edu, calling Health Information Management at (212) 606-1254, or asking for one at the time of your next visit.

By signing below, I acknowledge that I have been provided a copy of my physician Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the practice, and how I may obtain access to and control this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV/AIDS-related information, alcohol and substance abuse treatment information, and genetic information. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for service given to me, and for the business operations of this practice, its physicians, and staff.

_____ _____

Patient Name (Print) / DOB **Parent/Guardian Name if applicable (Print)**

_____ _____

Patient or Parent/Guardian Signature **Date**

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FINANCIAL INTEREST DISCLOSURE FORM
MEDICAL STAFF, ALLIED HEALTH PROFESSIONAL STAFF, RESIDENTS AND FELLOWS

As your treating physician and as a member of the Medical Staff of Hospital for Special Surgery (HSS), I would like you to know that I have financial relationships with the following orthopedics device companies, whose products I may use, or prescribe, for you during your care at HSS. The following will provide you with information about my financial relationships with these companies.

I am on the Scientific Advisory Board of Blue Belt Technologies and receive compensation for my time.

I am a consultant for Biomet and Stryker-MAKO for which I receive compensation for my time.

I do not receive payments from these companies for use of their products for your care at HSS or for the care of any other patients at HSS.

You should feel free to ask me any questions you may have about these financial interests. If you are not comfortable discussing this with me, you may contact David Altchek, MD, Co-Chief of Service (212-606-1909), or the Hospital's Office of Corporate Compliance (212-606-1592), with your questions or concerns or if you want any information about the Hospital's conflict of interest policies before deciding whether to continue with treatment.

If, because of the financial interest or relationship I have disclosed to you, you choose to refuse a particular treatment, or would like to revoke any informed consent you have previously given for a particular operation or procedure, you must sign the Hospital's "Refusal to Consent to Treatment" form. In either case, you can continue with other treatments at the Hospital without any penalty or loss of any benefit top which you may otherwise be entitled.

By signing below, you acknowledge that I have discussed the financial interest or relationship described above. You also confirm that you have read and fully understand this document, and that you have been given the opportunity to ask questions about my financial interest or relationship and your questions have been answered to your satisfaction.

_____	_____
Patient Name (Print) / DOB	**Parent/Guardian Name if applicable (Print)**
_____	_____
Patient or Parent/Guardian Signature	**Date**