ALLERGY & ASTHMA CARE OF MANHATTAN, PLLC
MARIANA MARCU, MD
Diplomate of American Board of Allergy & Immunology
Fellow of American Academy of Allergy & Immunology

Office and Financial Policies

We would like to thank you for choosing Allergy & Asthma Care of Manhattan, PLLC as your medical provider. To keep you informed of our current office and financial policies we ask that you read and sign our financial acknowledgement prior to any treatment. Please keep this document for future reference.

Insurance: Please bring your insurance card with you at the time of your appointment. For insurance plans that we contract with, your carrier requires that all co-pays be paid prior to any services being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. If you do not have your co-pay at the time of your visit, you must provide us a written waiver from your insurance carrier specifically authorizing Allergy & Asthma Care of Manhattan, PLLC to waive this obligation.
You are responsible for any co-insurance, deductibles or non-covered services as required by your insurance. You will receive a statement from our office indicating what your insurance has paid. Any remaining balance is due upon receipt of that statement

HMO or POS: For POS and HMO insurance plans that we participate in, your insurance carrier requires that you obtain a referral from your Primary Care Physician (PCP) before receiving services. Please bring that referral with you. Any services received without a referral or proper authorization will be your responsibility.

Private Pay Patients: As a private pay patient you will be asked to make a deposit prior to seeing the doctor. It is very important that you ask about the cost of care or services that your physician is recommending prior to the service being performed. At the end of my visit, I understand that I will receive a refund or expected to pay for additional charges.

Consent to treat Minor Patients

• For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

Assignment of Benefits

I hereby assign all medical benefits, to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to **ALLERGY & ASTHMA CARE OF MANHATTAN, PLLC** for medical services rendered to myself and / or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

Canceled Appointments: If you are unable to keep your scheduled appointment. Please call our office within 12 hours to reschedule your appointment. This will enable us time to use your slot for another patient.

Return Checks: A $35.00 charge will be added to your account for any check returned by your bank for any reason.

Medical Records: We will provide you a copy of your medical records upon request. You will need to sign a letter of release at the time of pick-up. Please allow 7-10 days for us to copy your records. If you wish for your records to be mailed, there may be an associated fee to cover the mailing costs. You may be charged for additional copies of your medical record.

●30 East 40th Street Suite 802
New York, N.Y. 10016
Phone: (212)481-1744
Fax: (212)481-0244

●155 Spring Street 4th Floor
New York, NY 10012
Phone: (212)343-3145
Fax: (212)481-0244

●37-11 88th Street
Jackson Heights, N.Y. 11372
Phone: (718)672-2343
Fax: (212)481-0244

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PATIENT NAME_______________________________

Patient Financial Responsibility
I acknowledge full financial responsibility for services rendered by Allergy & Asthma Care of Manhattan, PLLC. I understand that I am responsible for prompt payment of any portion of the charges not covered by insurance, including coinsurance, deductibles and co-pays. I understand payment of co-pays is expected at time of service, as well as any prior balance I may owe. I also consent that the payment of authorized Medicare insurance benefits be made on my behalf directly to Allergy& Asthma Care of Manhattan, PLLC for any medical services furnished. I agree to all reasonable collection costs in the event of default of payment of my charges, as outlined in office and financial policies guidelines.

Signed ____ Date ________________________

Consent for Purposes of Treatment, Payment and Healthcare Operations
I hereby give my consent to Allergy & Asthma Care of Manhattan, PLLC to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all protected health information contained in the patient record of
_______________________________________.

For a more detailed description of this consent and other uses and disclosures please review our Notice of Privacy Practices. I understand that Allergy & Asthma Care of Manhattan, PLLC reserves the right to change its privacy practices that are described in the Notice. I also understand that any Revised Notice will be posted on Allergy & Asthma Care of Manhattan, PLLC website, available at each office or I may request a copy be sent to me by mail.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.
Signed ____ Date ________________________

Acknowledgment – Notice of Privacy Practices

I hereby acknowledge receipt of Allergy & Asthma Care of Manhattan, PLLC Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential health information.
I understand that Allergy & Asthma Care of Manhattan, PLLC has reserved the right to change its privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided or made available to me.

Signed _______________________________________ Date _____________
If you are not the patient, please specify your relationship to the patient
____

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