

# NEW YORK UROLOGICAL ASSOCIATES, P.C.

**212-570-6800**

NOEL A. ARMENAKAS, M.D.  
JAMIE A. KANOFSKY, M.D.  
MARA A. MONOSKI, M.D.  
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JOHN A. FRACCHIA, M.D.  
ELI F. LIZZA M.D.  
JON M. RECKLER, M.D.  
JOHN H. WON, M.D.

Date: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI. \_\_\_\_\_

Address: \_\_\_\_\_ Apt: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Home #: \_\_\_\_\_ Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Office #: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Social Security#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone# \_\_\_\_\_

Marital status: \_\_\_\_\_ Spouse name: \_\_\_\_\_

Mother's 1st Name: \_\_\_\_\_ Father's 1st Name: \_\_\_\_\_

Primary Care Physician's Name)? \_\_\_\_\_ Email: \_\_\_\_\_

Address, city & state: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax#: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications (Current): \_\_\_\_\_

**\*\*\*BY LAW ALL INSURANCE INFORMATION MUST BE DISCLOSED\*\*\***

*PLEASE FILL IN USING THE CORRECT COORDINATION OF BENEFITS ORDER*

1. Name of Primary Insurance \_\_\_\_\_

Member ID# \_\_\_\_\_ Group/ Acct. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of birth: \_\_\_\_\_

2. Name of Secondary Insurance: \_\_\_\_\_

Member ID# \_\_\_\_\_ Group/ Acct. \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Relationship: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**If you have any other insurance, please write on the back.**

Reports should go to? (if different from Referring doctor): \_\_\_\_\_ Email: \_\_\_\_\_

Address, city & state: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax#: \_\_\_\_\_

880 Fifth Avenue  
New York, NY 10021  
Phone: 212-570-6800  
Fax: 212-861-7964

955 Park Avenue  
New York, NY 10028  
Phone: 212-570-6800  
Fax: 212-734-5762

245 East 54<sup>th</sup> Street  
New York, NY 10022  
Phone: 212-570-6800  
Fax: 212-734-7425

44-02 Francis Lewis Blvd.  
Bayside, NY 11361  
Phone: 718-732-7700  
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*Thank you, for choosing us as your Urological health care provider.*

We are committed to your treatment being successful. The following is a statement of our financial policy that we ask you to read and sign prior to any treatment.

## **ALL FORMS MUST BE COMPLETED AND SIGNED BEFORE SEEING A DOCTOR**

- ✓ **MEDICAID:** I understand that the practice is not part of the Medicaid program. As such I agree to pay for **ALL FEES** incurred as a result of medical care provided by NEW YORK UROLOGICAL ASSOCIATES, PC or any of their doctors.
- ✓ **PRIVATE INSURANCE:** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Therefore, **YOU ARE RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF VISIT**
- ✓ **PARTICIPATING INSURANCE:** All co-payments and deductibles are payable at the time of visit. Your signature below authorizes payments to us for our services. You are responsible for obtaining a referral number. If you do not, you are required to pay at the time of visit as an "out of network." If your insurance does not cover a special procedure and you would like it performed anyway, you are required to sign an acknowledgement and pay at the time of service. This waives your right to submit it to your carrier for denial.
- ✓ **MEDICARE INSURANCE:** We accept assignment. We will electronically submit your claim. Medicare will mail an Explanation of Benefits to you. You can then submit this to your co-insurance. I request that payment of authorized Medicare benefits be made to me or on my behalf to NY UROLOGICAL for services furnished to me. I authorized any holder of medical information about me to be released to the healthcare financing administration agents any benefits for related services.

**By signing below I confirm that I have provided all my correct information. I have not withheld any insurance information available to me. I also understand that I may be held responsible for any outdated information related to any participating insurance provided which would prevent your claims from getting paid. As such I agree to pay for any fees incurred as a result of the medical care provided by NEW YORK UROLOGICAL ASSOCIATES PC or any of its Doctors.**

### **\*\*\*MEDICARE BENEFICIARY NOTICE\*\*\***

Medicare will only pay for services that it determines to be "reasonable and necessary" under 1872(a) (1) of Medicare law. I have been notified on the date indicated that **Medicare is likely to deny payment for test/treatment if I exceeded the prescribed frequency for either the prescribed test/treatment.** I agree to be personally responsible for payment if Medicare denies payment.

### **\*\*\*RELEASE OF INFORMATION\*\*\***

I hereby authorize NEW YORK UROLOGICAL ASSOCIATES PC to release to insurance carriers or others who are, or may be financially responsible for my medical care, all information needed to substantiate payment for my medical care. I have read the above and agree to this policy as stated.

**Print Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signature** \_\_\_\_\_

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Date: \_\_\_\_\_

## ACKNOWLEDGMENT AND CONSENT HIPPA

By signing below, I acknowledge that I have read the Notice Of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the physician private practice listed at the beginning of this notice, 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, mental health information, and generic 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 services given to me, and for the business operations of this practice, its physicians, and staff.

\_\_\_\_\_  
1. Signature of Patient OR Patient's Personal Representative

\_\_\_\_\_  
2. Print Name of Patient's OR Personal Representative

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