CENTRAL PARK ENDOCRINOLOGY, PC
Richard R Neufeld MD
Robert M. Romanoff MD, PC
115 Central Park West
New York, NY 10024
Tel (212)877-2100 Fax212 873-9311

Referral Policy:

For all patients of our Primary Care Practice, if a referral is required for your plan, Please Contact our office 48 hours prior to your appointment or immediately after making the appointment at the specialist office.

We retain the right to refuse any referral to specialist if the patient has not adhered to our office policy. (Please discuss any and all medical issues with PCP first before scheduling appointments with a specialist office)

Financial Policy:

- Patients are ultimately responsible for the balance on account for professional services rendered in our office. This may include services not covered by your insurance policy. We can give you an estimate, not a guarantee of what percentage will be covered by your insurance company.
- Patients are responsible for updating your insurance information at each visit. If you fail to inform us of such changes, you will be responsible for the full fee on the treatment given. As a courtesy, we will help you by filing the claim.
- Patients should be fully aware of your insurance co-payments and limitations. If you have any questions about your insurance, you should contact the member services line listed on your insurance card.
- Patients are responsible for keeping scheduled appointments. If **24 hour advanced notice is not given, then a fee of 80.00 will be charged for the missed appointment**.
- **I understand the above-mentioned information and agree to all the terms. I agree that all amounts are due upon request and are payable Central Park Endocrinology, PC or alt practice**
- **If my account is not paid within 60 days of the date of service, I shall pay the reasonable legal fees or collection expenses to Central Park Endocrinology, PC.**
- **The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered. Deposit of 150.00 shall be required for service rendered on date of service for all Deductible plans.**

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Signature of Patient, Parent or Legal Guardian **Date**