ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

For office use only:

Patient Name: _____
Medical Record #: _____
Date of Admission: _____

By signing this form, you acknowledge that MANHATTAN SPORTS & SPINE MEDICINE AND SURGERY has given you a copy of its Privacy Notice, which explains how your health information will be handled in various situations. We must try to have you sign this form on your first date of service with us after April 14, 2003.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency.

Check all that are true:

[ ] I have received MANHATTAN SPORTS & SPINE MEDICINE AND SURGERY's Privacy Notice.

[ ] MANHATTAN SPORTS & SPINE MEDICINE AND SURGERY has given me the chance to discuss my concerns and questions about the privacy of my health information.

_____ _____
Patient's Signature Date

MANHATTAN SPORTS & SPINE MEDICINE AND SURGERY's staff should complete if Acknowledgement Form is not signed:

Does patient have a copy of the Privacy Notice?

[ ] Yes [ ] No

Please explain why the patient was unable to sign an acknowledgement form and MANHATTAN SPORTS & SPINE MEDICINE AND SURGERY's efforts in trying to obtain the patient's signature:

_____
_____
_____

Drew A. Stein, MD

FINANCIAL POLICY

We recognize the need for a definite understanding between you and your physician concerning healthcare and the financial arrangements for the medical care. Our commitment is to provide the very best healthcare to our patients. The responsibility for payment of fees for these services is the direct obligation of the patient. Any financial payment you may receive from private insurance or government agencies is a matter strictly between you and the insurance carrier or government agency. Our physician is a participating Medicare physician.

It is also your responsibility to know if your insurance has specific rules or regulations, such as the need for referrals from primary care physicians, pre-certification, limits on outpatient charges, specific physicians and/or hospitals to use. You should be knowledgeable of any referrals, deductibles, co-payments, and/or co-insurance. The same responsibility exists for HMO and PPO insurance.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO, or your employer. While we will try to be helpful, and we may participate in your plan, your benefit plan determines your coverage, requirements for prior authorizations or referral, and establishes the limit on your coverage for medical services.

PLEASE NOTE: PATIENTS ARE RESPONSIBLE FOR THEIR OWN REFERRALS. IF YOU NEED A REFERRAL WITH YOUR INSURANCE PLAN AND WE DO NOT RECEIVE IT AT THE TIME OF VISIT, YOU WILL BE HELD RESPONSIBLE FOR THE ENTIRE COST OF YOUR OFFICE VISIT.

PAYMENT POLICY:

Co-payments-	Full payment at the time of service
Deductibles-	Full payment at the time of service
Co-insurance-	Full payment at the time of service
Non-covered service-	Full payment at the time of service
Missed Appointments-	The office requires 48 hours notice (not including weekends) to cancel an appointment. Failure will result in a $25.00 fee.
Administrative Forms-	$20.00 fee
Medical Record Copies-	$0.75/page fee
Return Checks-	$20.00 fee
Cancellation of Surgery-	$1000.00 fee (<48 hours); $500.00 (3 to 7 days)

We realize that temporary financial problems may affect timely payments on your account. If such problems do arise, we encourage you to contact our office promptly for assistance to manage your account. If you have any further questions about this information please do not hesitate to ask.

I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and/or any insurance carrier or its agents any information needed to determine the benefits payable for related services. I understand that my physician is not aware of all services covered under by Medicare and/or private insurance coverage. I have received a copy of the Notice of Privacy Practices.

I certify that I have read and understand the above information. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any services rendered. I authorize payment of medical benefits to Drew A. Stein, MD when assignment has been taken. I request that payment of authorized benefits be made on my behalf for the duration of my care to Drew A. Stein, MD. I permit a copy of this authorization to be used in place of the original.

Patient Signature: _____ Date: _____

Patient Name: (Please Print) _____