Greenwich Health, PLLC
Julie Huang-Lionnet, MD
Board Certified Anesthesiology
Subspecialty Certification in Intervention Pain Management
Certified in Venous, Regenerative and Cosmetic Medicine
ABMS Boarded Anesthesiology/ABA Pain Medicine
greenwichhealth.org

PAYMENT POLICY

Thank you for choosing us as your provider for interventional pain management, venous medicine, regenerative medicine, sports medicine, and cosmetic medicine services. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. As your provider, please remember our relationship is with you and not your insurance company. Your benefit coverage is a contract between you and your insurance carrier. Please be aware that not all medical services are covered benefits under all insurance contracts. We encourage you to be familiar with your insurance benefits and limitations. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, you will be asked to reschedule your appointment.

You may receive multiple bills for the services provided. You will receive one bill for the physician (professional) services and one bill for the hospital (facility) fees. Your benefits for each of these may be different, so please check with your insurance carrier to understand your benefits.

Co-payments and deductibles. All co-payments and deductibles must be paid. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment.

Non-covered services. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pre-pay for these services in full prior to your visit.

Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 90 days, the balance will automatically be billed to you.

Nonpayment. If your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Cancellation / No Show / and Missed Appointment Policy. We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment.

Please help us to serve you better by keeping your regularly scheduled appointment. Our policy is to charge for missed appointments not canceled at least 24 hours in advance. These charges will be your responsibility and billed directly to you. This will not be covered by your insurance.

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Initial

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CANCELLATION AND PAYMENT POLICY

Greenwich Health understand that our patient's time is valuable. It is our sincerest aim to minimize our patient's waiting time and see them in a timely manner. This requires our patients to please keep their appointments and show up as scheduled.

If you must cancel/reschedule your **office** or **procedure** appointment, we ask that you provide **24 hours notice**.

You will be billed for these appointment types with **less than 24 hours cancellation notification** to the office as follows:

- **$50.00 fee for late arrivals** (if 10 minutes past for follow-up and 15 minutes past for new consults from appointment time, will have to reschedule appointment) which make it impossible for the physician to maintain her or his appointment schedule.
- **$100.00 fee for missed appointments and no shows** without a minimum of 24-hour notification.
- **$300.00 fee for missed procedure appointments** without a minimum of 24-hour notification.

If you arrived late past the allowed time to be seen, we will do our best to accommodate you and provide you the next available appointment. If the patient is a **"no-show" three times**, the patient will be discharged from the practice and require a new consultation from the referring provider.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

GUARANTY OF PAYMENT: I fully understand that I am directly responsible for payment to Greenwich Health, PLLC and their physicians for all medical services rendered to me. I also understand that all bills are payable and become due at the time of services rendered, unless other arrangements have been made. I agree to pay all collection costs including reasonable attorney's fees. I authorize payments to be made directly to my physician.

AUTHORIZATION FOR PAYMENT: I hereby authorize direct payment to Greenwich Health, PLLC for all insurance benefits, including for medical or surgical treatment received by me. I understand that I am personally and financially responsible to Greenwich Health, PLLC for any charges not covered by Insurance or designated as my deductible responsibility. I understand that I am personally responsible for services if my insurance company denies the claim. If my account is not paid, I will pay all costs, including but not limited to attorney's fees and court costs expended in collection efforts. I hereby authorize payment to Greenwich Health, PLLC physicians of my Medicare benefits for delivered services. I permit a copy of the authorization to be used in place of the original.

AUTHORIZATION FOR RELEASE OF INFORMATION: I understand that there may be times when Greenwich Health, PLLC is required to give or receive information relating to my treatment. I hereby authorize Greenwich Health, PLLC to release any information, acquired during my examination or treatment, to my insurance carriers or other parties responsible for payment.

I have read and understand the agreement and agree to abide by its guidelines. All of my questions and concerns regarding treatment have been adequately answered. I agree to follow these guidelines that have been fully explained to me. If I violate the agreement, I know that the practice may discontinue this form of treatment. A copy of this document has been given to me.

_____	_____	_____
Signature of Patient or Responsible Party	Print Name	Date
_____	_____	_____
Signature of Witness	Print Name	Date

Greenwich Health, PLLC
15 East Putnam Avenue, Suite 502, Greenwich, CT 06830
Phone (203)900-3996 • Fax (203)902-0166 or (203) 900-3998

Manhattan Office	Darien Office and
152 West 57th Street	AAAASF Accredited Procedure Suite
8th Floor - MCM	1472 Post Road
New York, NY 10019	Darien, CT 06820
Tel: 203-900-3996 •	Tel: 203-900-3996 •
Fax: 203-902-0166 or 203-900-3998	Fax: 203-902-0166 or 203-900-3998