DR. SCAFURI & ASSOCIATES

Internal Medicine, Pediatrics, and Infectious Diseases

Dr. Frank Scafuri, III	*Cheryl Lufrano, RPA-C*
Dr. Madhvi Rana	*Nicole Migliorini, MS, PA-C*
Dr. Azza Elemam	*John Lucente, NP-C*
Dr. Vincent Broillet	*Christina DePhilips, FNP*
Dr. Anita Jose	*Megan Saccente, FNP*
	Jordan Beyar, NP-C

PATIENT NAME:____ **DATE OF BIRTH:**____________________

ADDRESS: ____

CITY, STATE:____ **ZIP CODE:**___________________________

TELEPHONE NUMBERS-HOME:________________**WORK:** ________________**CELL:** ____________________

E-MAIL ADDRESS:____

SOCIAL SECURITY NUMBER:____

EMPLOYER:____

OCCUPATION:____

INSURANCE COMPANY:____

NAME OF INSURED (IF DIFFERENT):____

RELATIONSHIP TO INSURED:____________________________ **DATE OF BIRTH OF INSURED:**________________

SOCIAL SECURITY NUMBER OF INSURED:____

REASON FOR TODAY'S VISIT:____

____

EMERGENCY CONTACT NAME AND TELEPHONE NUMBER:____

WHOM MAY WE THANK FOR YOUR REFERRAL?____

INSURANCE AUTHORIZATION AND ASSIGNMENT:

I hereby authorize the above referenced practitioners to furnish information to insurance carriers concerning my illness and treatment and I assign to the practitioners all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

____________________________________ __________________________

PATIENT'S SIGNATURE DATE

3453 Richmond Avenue, Suite 200
Staten Island, New York 10312
(718) 605-4700 (phone)
(718) 605-8257 (facsimile)

682 Forest Avenue
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(718) 370-3730 (phone)
(718) 698-9412 (facsimile)

4143 Richmond Avenue
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(718) 966-5556 (phone)
(718) 966-7483 (facsimile)

Website: www.drscafuri.com *Email*: drfrankscafuri@gmail.com

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PATIENT'S NAME:____ DOB:________________

LANGUAGE SPOKEN:
- ○ English
- ○ Spanish
- ○ Korean
- ○ Other Language: ____________________________

RACE:
- ○ American Indian or Alaska Native
- ○ Asian
- ○ Black or African American
- ○ Native Hawaiian or Other Pacific Islander
- ○ White
- ○ Other Race: ____________________________

ETHNICITY:
- ○ Decline to State
- ○ Hispanic or Latino
- ○ Not Hispanic or Latino
- ○ Unknown

MARITAL STATUS:
- ○ Single
- ○ Married
- ○ Other: ____________________________

STUDENT STATUS:
- ○ Not a Student
- ○ Full Time
- ○ Part Time

Do you have an <u>ADVANCED HEALTHCARE DIRECTIVE</u>? (a legal document in which a you specify what actions should be taken for your health if you are no longer able to make decisions for yourself because of illness or incapacity)
- ○ Health Care Proxy
- ○ Living Will
- ○ Other: ____________________________

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I was provided with a copy of the Notice of Privacy Practices and I have read (or had the opportunity to read, if I so choose) and understood the Notice.

____

Patient's Signature Date

____

Parent's Signature or Authorized Representative (If Needed)

Please list the names of people you wish to receive your test results:

____

____

____

____

____

Please initial the box if we can leave results on your answering machine ☐

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PATIENT'S NAME:____ DOB:________________

FINANCIAL POLICIES

PATIENTS WITHOUT INSURANCE: If you do not have medical benefits, you must pay at the time of service.

PATIENTS WITH INSURANCE:

1. Our office will accept insurance assignment from a variety of insurance companies in order to help you meet your financial obligation for your treatment.
2. We will also process all claims related to your visit, including any vaccines that have been administered. Therefore, it is necessary for you to sign our assignment of benefits form.
3. Your insurance policy is an agreement between you and your insurance company. If the insurance company does not pay for your visit or any other ancillary services received from this office, you are responsible for your bill. Additionally, your co-pay is due before each visit.
4. If you discontinue care for any reason, your total account balance is due and payable immediately. If and when your insurance company sends us payment for services you have paid for, the payment will be returned.
5. In the event your insurance company requires you to obtain a referral for your visit or any other ancillary service received from this office, it is your responsibility to present this referral at the time of your appointment. In the event you do not have one, or the one you have on file has expired, your insurance company will not pay for the services rendered by this office and said payment will become your responsibility.
6. If, at the time of your visit, you do not have the required information to process your claim, such as your insurance card, no fault information or worker's compensation numbers, it is your responsibility to provide this information in a timely manner. If you do not provide this information and the claim is thereby denied, you will be responsible for these charges.

By signing below, you acknowledge that you have read the above Financial Arrangement Policy, you understand its terms and you accept full responsibility for all services rendered.

Thank you and welcome to our practice!

____________________________________ ______________________

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OFFICE POLICIES

1. Twenty-four (24) hour notice must be given to our office for all referrals that a patient needs to see a specialist.

2. Prior Authorizations and Pre-certifications require up to seven (7) business days to be obtained.

3. In order for disability papers to be completed, an office visit is required. Thereafter, it may take up to seven (7) days for them to be finished.

4. If your insurance company requires a referral for you to see Dr. Frank Scafuri, III as a specialist, the referral must be submitted at the time of your visit. If you do not have a referral at that time, you must pay for the office visit in cash or credit card. Upon receipt of a valid referral, your money will be refunded. Furthermore, if your referral has expired, it is your responsibility to obtain a new referral and submit that referral at the time of your office visit. Again, if it is not submitted, the office visit must be paid for in cash or credit card and your money will be refunded when the valid referral is submitted.

5. Medication that is considered a controlled substance will not be prescribed by the doctor on your initial visit. Also, an office visit is required for antibiotics to be prescribed.

6. Twenty-four (24) hour notice must be given to cancel your appointment. If said notice is not provided you will be billed fifty dollars ($50.00) as a cancellation fee.

7. If you had labwork or another test performed, please call the office seven (7) days after to confirm the results were received. Please do not assume that we received your results and all is fine. In some cases, we do not receive any results and there is no way for the doctor or his staff to know that you went for your test unless we are notified.

8. Your co-payment is due at the time of your visit. If you do not have the payment at that time, we will send you a bill, but a ten dollar ($10.00) service charge will be applied.

9. An appointment must be made to review any laboratory results. The doctor will **NOT** give any results over the telephone.

10. Our office does not accept checks as a form of payment for any services rendered. However, in the event, you do pay for a service by check, and that check bounces, you will be responsible for a twenty-five dollar ($25.00) processing fee together with any fees incurred by our office from our financial institution.

By signing below, you acknowledge that you have read the above Office Policies, you understand its terms and you agree to them.

____ ________________________

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PATIENT'S NAME:____ DOB:__________________

VACCINE POLICY

Please be aware that it is our office policy to collect payment for vaccinations prior to the time the vaccine is administered. We will submit the charge to your insurance company and, in the event we are reimbursed for the ***vaccine***, we will in turn reimburse you. Notably, your reimbursement will be in the form of check no matter how you made the payment for the vaccine. The following is a list of fees for the vaccines that we carry:

VACCINE NAME		COST
TDaP (tetanus)		$75.00
B12		$20.00
Depo-Medrol		$40.00
Hepatitis A Vaccine		$100.00
Hepatitis B Vaccine		$150.00
Haemophilus B Conjugate Vaccine		$50.00
Gardasil (HPV)		$250.00
Influenza Vaccine		$40.00
Meningococcal Vaccine		$175.00
MMR		$100.00
Polio Vaccine		$100.00
Pneumonia Vaccine	Prevnar	$200.00
	Pneumovax	$125.00
PPD		$30.00
Rabies Intramuscular		TBA
Twin Rx (Hep A & B Combination)		$125.00
Typhoid Vaccine		$125.00
Varicella Vaccine		$150.00
Yellow Fever Vaccine		$125.00
Zostavax (Shingles)		$275.00

The above cost is per vaccine, so if you are to receive multiple doses of the vaccine, please times the cost by the amount of doses. Involved in the administration of the vaccine is an office visit. As a result, in addition to the vaccine payment, you will be responsible to pay your co-pay at the time of your first visit. If your insurance company pays us for your office visit and not the vaccine, your payment will not be returned. Instead, as stated previously, if we are reimbursed by your insurance company for the ***vaccine***, we will in turn reimburse you. We do not accept checks for the payment of vaccines – all payments must be made either in cash or by credit card.

If payment is not taken when the vaccine is administered, and your insurance company denies payment, you agree to pay for the cost of each vaccine. Lastly, please be aware that payments and/or explanations of benefits from your insurance company may take more than one month for us to receive. Therefore, we ask for your patience with regard to your refund. By signing this form you acknowledge you have read the above, agree to the terms and acknowledge that you have received the *Center for Disease Control's Vaccine Information Sheet* regarding the vaccine being administered.

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DOCUMENTATION PREPARATION FEES

Please be aware it is the policy of this office to charge for the preparation of various documents that the physician and/or their staff are asked to complete.

FORM	FEE
1 Page Disability or Worker's Compensation Forms	$25.00
Multiple Page Disability or Worker's Compensation Forms	$50.00
CDL License Paperwork	$50.00
Chart Copies	$0.75 per page
Letters for Any Purpose	$10.00
Narrative Report	$400.00
School and/or Camp forms	$5.00 each
Weight Loss Letters (when weight loss not monitored by our office)	$300.00

Some of these fees are required to be paid in addition to the patient having an office visit with a practitioner. The office visit may be paid by your insurance company, but the fee must be paid by the patient in the form of cash or credit card.

Payment must be made **BEFORE** the document will be prepared. With the exception of a Narrative Report and Chart Copies, all documents will be sent to the place of the patient's choice within one (1) week. The time it will take for the preparation of the Narrative Report and the Chart Copies are based on a case by case basis.

By signing below, you acknowledge that you have read the above Documentation Preparation Fee Form, you understand its terms and you agree to them.

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PHYSICIAN PARTICIPATION AND AFFILIATION INFORMATION

Below is the list of health plans in which the practitioners of Frank Scafuri, III, D.O., P.C. participates and the hospitals with which they are affiliated:

Participates in the following health plans:
Aetna, Affinity (as specialists ONLY), Amida Care (as specialists ONLY), Community Plan by United HealthCare, Cigna, Elderplan, Emblem GHI and HIP, Empire Blue Cross/Blue Shield, Empire Plan by United HealthCare, EverCare, Fidelis, First Health, HealthCare Partners, Health Plus/Amerigroup (as specialists ONLY), MagnaCare, Medicaid (as a secondary insurance plan), Medicare, Multiplan, Oxford (Freedom and Liberty), Touchstone, Tricare, United HealthCare, USFHP, 1199, Most Union Locals, Workers Compensation, and No Fault.

Affiliated with the following hospital:
Richmond University Medical Center

This information is also available at: www.DrScafuri.com.

If your health plan is not listed here, then the physician **DOES NOT** participate in your plan, and any services provided may be out-of-network. You should also check with your health plan to confirm that the physician participates in your specific health plan product, even if the health plan is listed above.

Estimated charges for out-of-network services are available upon request.

I acknowledge that I have received information about the health plans in which my doctor participates. I understand and agree that I am financially responsible for any out-of-network costs if my doctor does not participate in my health plan or product.

_____________________________________ ______________________

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REFERRALS TO OTHER PROVIDERS

You have elected to receive services from practitioners of Dr. Scafuri & Associates. One of the practitioners of Dr. Scafuri & Associates may be referring you to or coordinating services from another provider. These services are required as part of your treatment during your office visit.

These services may include: Radiology Services, Pathology Services, Laboratory Services, or Diagnostic Services.

Similarly, you may be having a scheduled hospital admission or outpatient hospital services/procedure.

You **MUST** contact the other physician(s) or your health plan to determine if the other physician(s) participates in your health plan.

I understand that other providers may be involved in my care. I understand that it is my responsibility to determine if the other providers participate in my health plan.

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