65th street GI Office-Based Surgery

within the offices of
Yaffe Ruden & Associates
201 East 65th Street
New York, New York 10065

Billing Consent Form

You have been scheduled for an endoscopic procedure: colonoscopy, gastroscopy or both. For your safety and comfort you will receive a mild anesthesia, lasting only for the duration of the procedure, administered and supervised by Dr. Graziano Carlon, a Board-Certified Anesthesiologist. Dr. Carlon is not an employee of Yaffe Ruden, LLP, and will submit a separate bill to your Insurance.

Please contact your insurance or Dr. Carlon - (646)361-4800, (646)244-0950
or gccarlon@aol.com - to determine whether he participates in your plan.

Some insurances such as SAG or Guardian, do not cover the anesthesia fee. Also, you may have a high deductible, which may reduce or even eliminate payment. Please check the terms of your policy with your insurance or contact Dr. Carlon.

If you are not insured, or if your insurance denies payment, you will be billed a reasonable amount for the Anesthesia services. If you have any financial concerns, please discuss them with Dr. Carlon before the procedure. Every reasonable effort will be made to make sure cost considerations do not interfere with your care.

Some insurance companies may send the payment directly to you. Please do not cash the check, but forward it to:

Graziano C. Carlon, M.D.
Lenox Hill Station
P. O. Box 1448
New York, NY 10021

At the time of service Dr. Carlon will usually collect a credit card authorization to cover co-pay, co-insurance, deductible and minimum payment and as a guarantee for payments sent directly to you

I have discussed the anesthesia charges with Dr. Carlon and I understand that I am responsible to forward to him without delay any payment I should receive from my Insurance. I am also responsible to follow-up on any insurance payment until it is received by Dr. Carlon.

I also authorize Dr. Carlon to file any necessary verbal or written appeal with my insurance, which may result in a reconsideration of the anesthesia charges.

My out-of-pocket expenses will not exceed $ (amount to be agreed) regardless of the amount approved or paid my Insurance if my bill is paid timely upon request.

I understand that any discount will only apply if my bill is paid promptly when payment is requested. If collection becomes necessary, I will be responsible for the full amount of the anesthesia charges.

Name: _____ Date: _____
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