Sofiya Prilik, M.D
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Brooklyn, NY 11230

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Patient Financial Responsibilities

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy.We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

- We accept certain insurance plans; therefore please provide us with your insurance card. We will let you know if your plan is one for which we are a designated provider. If you wish to be seen by Dr. Sofiya Prilik you are responsible for payment of all co-pays and or deductible charges at the time of service. If your insurance is a plan for which we are not a designated provider, we are more than willing to provide care and you will be responsible for payment at the time of service.

- Please remember that insurance policies may not cover all conditions and fees. To be fully aware of your schedule of benefits, please read your insurance policy or talk with an insurance representative.

- Any laboratory analysis that we require, but do not perform in-house will be sent to an external laboratory as required by your insurance. You may receive a separate bill for laboratory services.

I have read this financial policy and understand that I have financial responsibility for payment of medical services provided by Dr. Sofiya Prilik and hereby assume and guarantee payment of all expenses incurred during my office visit.

X_____ _____

Signature of Patient/ Responsible Party Date

HIPPA Privacy Practices

Our Notice of Privacy provides information about how we may use and disclose protected health information about you. The Notice contains a section concerning Patient Rights under the law. The Notice is available to you at the front desk at your request. You may review the Notice before signing this consent. The patient has the right to restrict the uses of their information.

- By signing this form, you acknowledge that you have read and understand our Notice of Privacy Practices and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage and payment from your health insurance company and overall health care operations. You have the right to revoke this consent in writing with your signature.

X_____ _____

Signature of Patient/ Responsible Party Date