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**DO NOT COMPLETE THIS FORM IF YOU ARE COVERED BY
MEDICARE OR ANY OTHER GOVERNMENT PROGRAM**

Dear Patient:

We value you as a patient and respect that you have entrusted us for your health care.

Our office is pleased to be helpful to you regarding your health benefit plan. Please remember, 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 be participants in the plan, your health benefit plan determines your coverage, any requirements for prior authorizations or referrals and establishes the limits on your coverage for medical services.

We agree to accept responsibility to provide you with appropriate and compassionate medical services as may be medically necessary.

You agree to accept financial responsibility for co-payments, deductibles, and medical care and other services that are provided to you which are not specifically covered by your health benefit plan or not covered due to the absence of authorizations/referrals you are obligated to obtain under your health benefit plan. The services, plans and benefits under your health plan may be subject to and governed by applicable contracts and government regulations. This agreement is not intended to conflict with or circumvent the provisions of such contracts and regulations, including any provisions regarding grievance procedures that may be available to you.

Name

Signature

Date