

Nuclear Medicine Associates
1 Gustave Levy Place #1141
New York, NY 10029 (212) 241-5998



Patient Last Name: EPSTEIN

Social Sec. #:

Patient First Name: JEFFREY

Preferred Phone #

Date of Birth: JAN. 20, 1953 Sex: M F

Address:
9 EAST 71ST STREET
NY NY 10021 USA

Referring MD:

Employer Name: SOUTHERN TRUST CO.

Phone: 340-775-2525

Primary Insurance: UNITED HEALTHCARE

Policy #:

Name of Policyholder: JEFFREY EPSTEIN

Policyholder Date of birth: JAN. 20, 1953

Relationship to Policyholder: Self Spouse Child Other

Secondary Insurance:

Policy #:

Name of Policyholder:

Policyholder Date of birth:

Relationship to Policyholder: Self Spouse Child Other

I request that payment of authorized Medicare or other medical benefits be made on my behalf to the physician practice. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____

Date: DEC 13, 2017

Office use:
E #:

Policy Holder Signature: _____

Date: DEC 13, 2017

V #:



Mount Sinai Doctors

AUTHORIZATIONS AND ASSIGNMENTS

PLACE LABEL HERE

1. FINANCIAL AGREEMENT/GUARANTEED OF PAYMENT (All Patients) Yes No (Please initial)

In consideration of services, assignment of benefits and care rendered; I agree that I am responsible for any and all charges billed by Drs. (the "Physicians") with respect to such services and care unless the contract between the Physicians and my insurance company provides otherwise. In the event that the requested services are not specifically authorized by my insurance company, I agree to pay for all services as agreed upon, unless otherwise provided by law.

I authorize payment of medical benefits to which I am entitled directly to the Physicians, to cover the cost of the care and treatment rendered to myself or my dependents in the office.

Upon receipt of a medical bill, I agree to immediately pay all amounts not covered by insurance. If any insurance I have rejects my claim or pays part of the claim, I shall be responsible for payment of any balance as determined by Mount Sinai immediately upon learning of such coverage, unless otherwise provided by law.

2. RELEASE OF INFORMATION Yes No (Please initial)

In the event my insurer denies payment to the Physicians for services rendered to me, I hereby give my consent to have an authorized representative of the Physician to contact my insurer and to provide to my insurer all information and documentation regarding the services rendered to me by the Physicians which may be required in order for my insurer to reevaluate its decision to deny payment for such services.

I authorize this practice, my treating physician, and their respective designees to use and disclose my health information for all necessary treatment, payment and health care operations purposes. I acknowledge that my health information may include information relating to mental illness and/or AIDS/ARC/HIV and that any such information may be disclosed (including examination and copying in either hard copy or digital format) to insurers, various credit agencies and guarantors solely if needed for payment of the professional charges (no clinical information will be disclosed to any credit agency).

3. MEDICARE-RELEASE OF INFORMATION & ASSIGNMENT OF BENEFITS (Medicare only - Part B providers) Yes No (Please initial)

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information (including information relating to mental illness and/or AIDS/ARC/HIV) needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign benefits payable to physician (s) and/or the (s) or organizations providing the service (s)

4. INSURANCE NETWORK/PROVIDER NOTICE PURSUANT TO NYS "OUT-OF-NETWORK" LAW

I understand that the Physicians may be participating providers in certain health plan networks, and that a list of the plans that the Physicians participate in can be found on their website or can be provided to me upon request.

I understand that the Physicians may not participate in the same health plans and networks as the hospitals and facilities in the Mount Sinai Health System even though the Physicians may be employed by or affiliated with hospitals or facilities in the Mount Sinai Health System. I understand that I can determine the health plans participated in by physicians who are employed or contracted by Mount Sinai to provide hospital services by visiting <http://www.mountsinai.org/patient-care/find-a-doctor>; I also understand that I can also determine the health plans accepted by hospitals and facilities in the Mount Sinai Health System by visiting the facility's web portal.

I understand that the Physicians charge for their services separately from the hospitals and facilities in the Mount Sinai Health System, and that any bills from hospitals or facilities in the Mount Sinai Health System for so-called "facility" or "technical" fees will be sent separately from the Physicians bills for their "professional" services.

I understand that it is my responsibility to check with the "physician" arranging for my services regarding: (1) whether the services of any other physicians (including but not limited to anesthesiologists, pathologists, and/or radiologists) may be reasonably anticipated to be provided in connection with my care. I further understand that I can check with the "physician" arranging for my services to obtain the contact information and/or health plan participation information for any physicians or facility whose services may be needed in connection with my care, and that I can also contact those physicians directly to obtain information regarding their health plan participation.

I HAVE READ, UNDERSTAND AND AGREE WITH THE ABOVE ITEMS.

SIGNATURE OF PATIENT OR AUTHORIZED REPRESENTATIVE

DEC. 13, 2017 DATED

RELATIONSHIP TO PATIENT

WITNESS TO SIGNATURE

Please Turn Page Over

**Icahn School of Medicine at Mount Sinai
Mount Sinai Doctors Faculty Practice
Financial Agreement**

Welcome to Mount Sinai Doctors Faculty Practice (MSDFP), a division of the Icahn School of Medicine at Mount Sinai. We are committed to providing you with the best possible care and are pleased to explain our professional fees to you at any time. Your clear understanding of our Financial Agreement is important to our professional relationship. Please ask if you have any questions about our fees, our financial policy, or your financial responsibility.

PATIENTS MUST FILL OUT PATIENT INFORMATION FORMS PRIOR TO SEEING THE DOCTOR. WE WILL ALSO PHOTOCOPY YOUR INSURANCE CARD(S) FOR YOUR FILE.

- **REFERRALS** – If your plan requires a referral from your primary care physician, it is YOUR responsibility to obtain it *prior to* your appointment and have it with you at the time of your visit. If you do not have your referral, and cannot obtain one at the time of your visit, you will be personally responsible for that day's services.
- **CO-PAYMENTS** – By law we MUST collect your carrier's designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.
- **OUT OF NETWORK PLANS** – If your provider does not participate with your plan, payments for any co-insurance, deductible and non-covered amount is expected at the time of service *unless* prior arrangements have been made with our financial staff. We will send a courtesy bill to your insurance carrier on your behalf.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to MSDFP for any services furnished. I understand that I am financially responsible for any amount not covered by my health insurance contract. I also authorize any holder of medical information about me to be released to my insurance company (or its agent) concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims for benefits.

- **SELF-PAY PATIENTS** – Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.
- **MEDICARE** – We will submit claims to Medicare. You will be responsible for the deductible and the 20% co-insurance, which can be billed to a secondary insurance if you have one.

Medicare Lifetime Signature on File: I request that payment of authorized Medicare benefits be made on my behalf to MSDFP for any services furnished to me. I authorize any holder of medical information about me to release it to the CMS (and its agents) to determine the benefits payable for related services. This information will be used for the purpose of evaluating and administering claims for benefits.

- **DIVORCED/SEPARATED PARENTS OF MINOR PATIENTS** – The guarantor is responsible for payment for services rendered. MSDFP cannot be involved with separation or divorce disputes.

You are responsible for the timely payment of your account. Our financial staff will work closely with you and your carrier to avoid sending any account to an outside agency to collect payment. We reserve the right to send delinquent accounts to an outside collection agency.

We accept CREDIT CARDS (MASTERCARD, VISA, or AMERICAN EXPRESS), CASH, or CHECKS. Our preferred method of payment is by credit or debit card.

THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share any special concerns you may have with a member of our staff.

Patient Name: JEFFREY EPSTEIN	Patient Signature:	Date of Birth: JAN. 20, 1953
Patient Address: [REDACTED]	City, State: NY, NY	Zip: 10021
Today's Date: DEC. 13, 2017		
Guarantor Name: (if not the patient)	Guarantor relationship to patient:	Guarantor Signature:

Please Turn Page Over



Patient Name: JEFFREY EPSTEIN

MRN: _____

INFECTIOUS DISEASES SCREENING TOOL

Assigned staff should have ALL patients answer these questions:

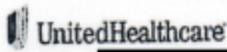
1. Have you traveled outside the U.S. in the past 21 days (3 weeks)? If yes, where <u>PARIS, FRANCE</u>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Has a close contact (household member) traveled outside the U.S. in the past 21 days (3 weeks)? If yes, where _____	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
2. Have you had close contact with a person with Ebola?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
3. Do you have a fever (Temp more than 100.4°F (38°C)) or feel hot?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No
4. Do you have a cough or a sore throat?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Are you vomiting or having diarrhea?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you have a rash?	<input type="checkbox"/> Yes <input type="checkbox"/> No

* During FLU season, think FLU *



SOUTHERN TRUST COMPANY
6100 RED HOOK QUARTER, B-3
ST THOMAS VI 00802-0000

ST THOMAS VI 00802-0000
JEFFREY EPSTEIN
>002669 7080107 003082



03082 7080107 0000 002669 0001 351 9 116

Health Plan (BC) [REDACTED] Number: [REDACTED]
Member ID: [REDACTED] SOUTHERN TRUST COMPANY
Member: JEFFREY EPSTEIN
Payer ID: [REDACTED]

Office: \$20 ER: \$200
UrgCam: \$75 Spec: \$30

OPT
Rx Bin: [REDACTED]
Rx PCN: [REDACTED]
Rx Grp: [REDACTED]

UnitedHealthcare Choice Plus
Underwritten by UnitedHealthcare Insurance Company

Thank you for being a UnitedHealthcare member! We are proud to serve you.
Your UnitedHealthcare health plan identification (ID) card is attached. Please check your card to be sure all information is correct. If not, please let us know by calling the member number on the card. You may begin using your card on your effective date. Remember to take your ID card to your appointments and have it ready if you call us with questions.

Sign up for myuhc.com and download the UnitedHealthcare Health4Me® mobile app to find tools and information to help you manage your health and benefits at home and on the go. You can find network doctors, track and pay claims, estimate costs, and more. You can even view, download or print a copy of your ID card.

We're here to help. If you have questions, visit myuhc.com or call the toll-free member phone number on your ID card. TTY users call 711.

Gracias por elegir UnitedHealthcare

Con su nueva tarjeta de identificación médica de miembro de UnitedHealthcare, usted tiene acceso a servicios que pueden ayudarle a llevar una vida más saludable.

Su nueva tarjeta de identificación está diseñada para proporcionarle una mejor experiencia como miembro, incluyendo su lealtad y transferencia de información. Puede comenzar a usar su tarjeta inmediatamente al día de entrada en vigencia de su cobertura o después.

This card is for identification only. It is not proof of membership and it does not guarantee coverage.

Printed: 12/17/15



Members: We're here to help. Check benefits, view claims, find a doctor, ask a question and more.

Web: www.myuhc.com Call anytime to speak with a Nurse
Email: Advocate4me@uhc.com
Phone: 800-782-3740
Mental Health: 800-842-2055

Providers: 877-842-3210 or www.UnitedHealthcareOnline.com
Medical Claims: P.O. BOX 740800 ATLANTA GA 303740800
PR - MAPFRE - PO Box 70297, San Juan, PR 00936-8297

MultiPlan
Pharmacists: 888-290-5416
Pharmacy Claims: OptumRx PO Box 29044 Hot Springs, AR 71903

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