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Phone 301-754-3870  
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### **FINANCIAL POLICIES**

I authorize payment of medical benefits to Dr. Cynthia L. Long, M.D., LLC for services provided.

I agree to pay in full any balance for services that are deemed to be my responsibility. This may include services denied by my insurance as non-covered, applied to my deductible, part of my coinsurance, etc. If I fail to pay in a timely manner, I understand that my account will be sent to a collection agency and I will be discharged from the practice. I agree to be financially responsible for any collection fees incurred.

I understand that it is my responsibility to provide the office of Dr. Cynthia L. Long, M.D., LLC with my current insurance card at the time services are rendered to me. If I cannot provide my current insurance card, my appointment will be rescheduled. I understand that if I provide incorrect or expired insurance information I will assume full financial responsibility for all charges incurred.

I understand that payment is due at the time services are rendered and that there is a \$10.00 billing fee for co-payment not paid at the time of service.

\_\_\_\_\_  
**Patient Name (print)**

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**DATE**

### **NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT**

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment both directly and indirectly.
- Obtained payment from third-party payers (insurance companies).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that Cynthia L. Long, M.D., LLC has the right to change this Notice of Privacy Practices from time to time and that I may contact the office during normal business hours to request a copy of the most current Notice of Privacy Practices.

\_\_\_\_\_  
**Patient Name (print)**

\_\_\_\_\_  
**Signature of Patient or Legal Guardian**

\_\_\_\_\_  
**DATE**

### **PATIENT AUTHORIZATION**

I, \_\_\_\_\_, hereby authorize Cynthia Long, M.D., to apply for benefits on my behalf for covered services rendered. I request payment from BC/BS National Capital Area, Blue Shield of Maryland, Medicare, and / or \_\_\_\_\_ Insurance Company, be made directly to the above-named provider (or in case of Medicare Part B benefits, to myself or the party who accepts assignment).  
(Name of other insurance company)

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claim, to the above-named billing agent, (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) and / or the insurance company named above. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or the above - named carrier at any time in writing.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the above-named provider for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to \_\_\_\_\_ any information needed to determine these benefits payable for related services.  
(Name of Medigap Carrier)

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF SUBSCRIBER OR BENEFICIARY**