

ROBERT BOS, M.D.  
515 Madison Avenue, 6<sup>th</sup> Floor  
New York, NY 10022  
P: 212-752-6770  
F: 212-754-0369

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First dd/mm/yyyy

Address: \_\_\_\_\_  
Street City, State Zip Code

Gender (please circle one): Male Female Marital Status: Single Married Divorced Widowed

Home Phone: \_\_\_\_\_  check if cellular phone Work: \_\_\_\_\_

Email Address: \_\_\_\_\_

*We confirm all patient appointments via email.*

Check here if you would like to be added to our health newsletter mailing lists.

Primary Care Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Who referred you to this office?: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer's Address: \_\_\_\_\_  
Street City, State Zip Code

Occupation: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Member ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Relation to insured (please circle one): Self Spouse Dependent Child Other

If different from self, policy holder name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
dd/mm/yyyy

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

*I consent to treatment that is received in this office. I understand that my personal information is available to all medical providers at this location. I have received a copy of the office's notice of privacy practices and authorize the release of any medical or other information necessary to process a claim with my insurance. I request payment of insurance benefits either to myself or the party accepting assignment. I understand that I am responsible for any copay, deductible or expenses incurred that are not covered under my medical insurance.*

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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**PRIVATE PATIENT FINANCIAL RESPONSIBILITY**

Patient Name: \_\_\_\_\_

Fees for Dr. Bos' services are as follows:

**Routine Physical**

*Includes EKG, spirometry, hearing test, and blood work*

New Patient	\$450.00
Established Patient	\$375.00
Medicare Patient*	\$375.00

*\*Note to Medicare patients: An annual routine physical exam is recommended but is not a covered service under Medicare insurance. Medicare patients who wish to receive an annual physical are subject to the private fee of \$375.00 at the time of service.*

**Diagnostic/Treatment**

Follow-Up	\$125.00
Sick Visit – Established	\$150.00
Sick Visit – New	\$175.00
Visa Examination	\$250.00
Blood work	\$35.00
EKG	\$100.00
Spirometry	\$100.00
Hearing Test	\$75.00
Echocardiogram	\$500.00
Carotid Ultrasound	\$200.00
Chest X-Ray	\$125.00
Sinus X-Ray	\$100.00
All Immunizations	\$75.00

I, \_\_\_\_\_, understand that I am responsible for payment of the fees applicable for the services rendered by Dr. Bos at each appointment. I understand that the fees for these services are subject to change and I will be notified of that prior to receiving treatment. I understand this list is not exhaustive and additional fees may be incurred, which I will be aware of prior to receiving treatment.

\_\_\_\_\_  
*Patient Signature (or guardian, if minor)*

\_\_\_\_\_  
*Date*

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**PATIENT FINANCIAL RESPONSIBILITY**

Patient Name: \_\_\_\_\_

Insurance: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Total Insurance Deductible: \_\_\_\_\_

Total Paid to Date: \_\_\_\_\_

Total Remaining: \_\_\_\_\_

(Owed before reimbursement begins)

**Deductible Payments** (coinsurance payments will not take effect until deductible payments have been satisfied):

\_\_\_\_\_ Please see attached form for private fees.

**Coinsurance payment** (per visit, after deductible payments have been made): \_\_\_\_\_

Per your insurance carrier, as out-of-network providers, it is mandatory that we collect all deductibles and co-insurance as determined by your insurance plan. Your insurance plan is a contract between you and your insurance company. Dr. Robert Bos is not party to that contract. We will do our best to verify your out-of-network benefits, deductibles, and co-insurance. We recommend that you do the same. Regrettably, we may not be able to determine the extent of your payment responsibility at the time of your visit.

In some cases, patients may choose to receive services that are not covered by insurance, and are financially responsible to pay for such services as will be discussed prior to receiving those services.

I, \_\_\_\_\_, understand that I am responsible for payment of the applicable deductibles/co-insurance for services rendered by Dr. Robert Bos. I understand that I am responsible for providing Midtown Integrative Health & Wellness with up-to-date insurance information and appropriate referrals, if required by my insurance plan.

\_\_\_\_\_  
*Patient Signature (or guardian, if minor)*

\_\_\_\_\_  
*Date*

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I understand that all providers at Midtown Integrative Health & Wellness are out-of-network with all insurances. I understand that some insurance carriers do not allow out-of-network providers to be paid directly, and thus will send office visit payment checks directly to the patient, even though Midtown Integrative Health and Wellness has submitted the claim for payment for services rendered. I understand that I am responsible for any deductible, coinsurance amount, and should I receive payment from my insurance company for the services rendered by any and all of the providers at Midtown Integrative Health & Wellness, that I am responsible to either endorse and provide the check to the provider(s); and/or provide payment for the same amount via credit card or personal check. I understand that should my insurance company deny services provided, I may be responsible for the balance.

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Print Name

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Signature

Date