Patient Financial Responsibility Agreement for Synvisc One

Prior to receiving a Synvisc One injection **you will need to contact your insurance carrier to determine if (1) Synvisc One is a covered benefit, and (2) if pre-authorization is required.**

When you contact your insurance carrier they will need the following information:

Procedure Code: 20610 Injection

J7325 Synvisc One 48 units

Plan Number and other information on your insurance card

I understand that although Rochester Community Orthopaedics, LLP participates with my Health Plan, the injection I am requesting may not be a covered benefit, or pre-authorization may be required. I will inform Rochester Community Orthopaedics if pre-authorization is required after I have spoken with my insurance carrier.

I understand that a deposit of $130.00 plus any copay is due at the time of service, regardless of pre-authorization status. In addition I agree to pay the full cost of the service described below if my insurance carrier denies payment.

Procedure Code 20610	$70.00
Synvisc One J7325	$700.00
Total	$770.00

If I am a HMO member, my signature does not imply, nor shall it be interpreted as being, a waiver by me of my rights to grieve and appeal under Public Health Law (PHL) Article 44, or to appeal an initial or final adverse determination under PHL Article 49 or Insurance Law Article 49. If I am an enrollee under an employer-sponsored self-insured plan, I do not waive my grievance and appeal rights under the health plan.

I acknowledge that Rochester Community Orthopaedics disclosed this information to me and I signed this agreement **before** the specified health service was performed.

___________________________	___________________________
Patient Name (please print)	Patient's Member ID
___________________________	___________________________
Patient Signature	Date
___________________________	___________________________
Provider Name	Provider Signature