



ocpn | easton

ORTHOPEDIC CARE PHYSICIAN NETWORK
& REHABILITATION SERVICES

Members

- Simon Chao, M.D.**
- Simon M. Cornelissen, M.D.**
- Jason C. Fanuele, M.S., M.D.**
- Raymond Pavlovich, Jr., M.D.**
- Anthony Wong, M.D.**
- David S. Worman, M.D.**

Associates

- Zachary Bohart, M.D.**
- Tracy Frombach, D.O.**
- Vincent Iacono, M.D., F.A.C.S.**
- Stanley M. Leitzes, M.D.**

Specializing in:

- General Orthopedics*
- Trauma*
- Total Joint Replacement*
- Sport Medicine*
- Arthroscopic Surgery*
- Hand & Upper Extremity*
- Foot & Ankle*
- Spine*
- Pain Management*

Physician Assistants

- James Bender, PA-C
- Carrie Disa, PA-C
- Phuong K. Duong, PA-C
- Jenny R. Fanuele, PA-C
- Disha Mankanji, PA-C
- Alison B. Moore, PA-C
- Willy Moy, PA-C
- Ryan Murphy, PA-C
- Meaghan Reynolds, PA-C
- Maseo Tran, PA-C

Nurse Practitioner

- Karen Lewandowski, MSN, RNFA, NP-C

Physical Therapy

- Eric J. Folmar, DPT, OCS
- Judith Colandreo, MSPT, LATC
- Rebecca C. Smith, DPT, COMT
- Christopher A. Hunt, MSPT
- Rachel L. Quinlan, MSPT
- Ashley D'Ambr, DPT
- Richard McLaughlin, DPT

Occupational Therapy

- Gretchen Johnson, MS OTR/L, CHT
- Teresa Rettman, OTR/L, CHT

Administrator

- Rick Fopiano, CPA

Emeritus

- William Sullivan, M.D.
- B. Hoagland Rosania, M.D.

YOUR INSURANCE

In order for Orthopedic Care Physician Network to submit on your behalf to your insurance carrier, the assignment of benefits below needs to be completed. Having insurance is not a substitute for payment. Many companies have fixed allowances or percentages based upon your contract with them, not with our office. It is your responsibility to pay deductible, co-insurance and any other balances in compliance with existing contractual agreements. We will do all we can to assist you in receiving reimbursement, but you are responsible for your bill.

HMO/PPO/COMMERCIAL INSURANCE SIGNATURE AGREEMENT

I request that the payment under my HMO/PPO/Commercial Insurance program be made on my behalf to Orthopedic Care Physician Network for services furnished to me by that provider. I further authorize Orthopedic Care Physician Network to release any information to determine benefits payable for related services.

This authorization is in effect until I choose to revoke it.

Print Name: _____ Date: _____

Signature: _____

I understand that I am financially responsible for co-payments and/or deductibles in accordance with the provisions of my insurance plan. If covered under an HMO, I understand it is my responsibility to obtain a referral (when required). I further understand that if I do not obtain a referral when it is required by my plan, coverage for services may be denied by my HMO/PPO/Commercial Insurance and that it is my responsibility to make payment in full to Orthopedic Care Physician Network for those non-covered services.

I have read this information and understand it.

Print Name: _____ Date: _____

Signature: _____

(parent if under age 18 or other responsibility party)

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