STATEMENT OF ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

DISCLAIMER

Dr. Jane M. Fitzgerald
3170 E. Tremont Avenue
Bronx, NY 10461
718-824-2002

I understand that I may be financially responsible for any charges incurred at this office, including co-pays, deductibles, and charges denied or not covered by my insurance company.

I realized my care may be subject to pre-certification by the insurance company, and I accept any responsibility for charges which may not be approved. The insurance company will review any/all documentation submitted by Dr. Jane M. Fitzgerald for review for medical necessity and base their approval/denial upon this documentation.

I understand that this office agrees to notify me as soon as possible if a service is not covered and will notify me if my care is not approved by the insurance company. If a treatment plan is approved, this office will make me aware of the number of office visits allowed and the timeframe of the certification. Initial visits may be denied and this may be beyond the office's ability to notify the patient prior to rendering acute care, while waiting for insurance coverage approval. These charges will be the patient's responsibility if denied by the insurance company.

The office may seek payment from you for any services your health insurance plan determines to be not medically necessary.

I have read and understand my obligation for payment for care in the absence of insurance coverage.

_____ _____

PRINT PATIENT'S NAME SIGNATURE (PATIENT, PARENT OR GUARDIAN)

_____

DATE