Dr. Zina B. Cappiello DPM, LLC

INSURANCE

Although I have health insurance, I am aware that this is no guarantee of payment. If my insurance company denies payment, I understand that I am ultimately responsible for this bill.

If my insurance requires a referral, it is solely my responsibility to obtain the referral before my office visit. If I do not obtain the referral prior to the visit, payment for the visit is my responsibility.

I am responsible to notify the office of any and all changes in my health insurance and present updated cards in coordination. If I do not provide accurate information, I am responsible for payment of the office visit.

I hereby authorize and guarantee payment for all services rendered.

Although fees for services are due and payment expected at the time services are rendered, if I have been granted a grace period for payment of fees, I acknowledge that payment is due and expected at the time the billing statement is received.

I hereby Authorize the release of any medical information Necessary to process my claims and hereby assign to the Physician all payments for Medical Services rendered to my dependents or myself.

_____ Date _____

Print Patient Name

_____

Patient Signature or Responsible Party