STEVEN J COVICI, MD, FACS

Financial Responsibility

Patient's Name: _____ Date: _____

As a patient of Steven J. Covici, MD, FACS, I have been informed of the following:

- It is my responsibility to know if there are any deductibles, copays, clauses and/or exclusions in my insurance policy that would prevent the insurance company from paying any of my claims.
- It is my responsibility to provide Steven J. Covici, MD, FACS with accurate insurance information to submit claims on my behalf.
- My insurance company may not cover ALL physician fees, and I will be responsible for payment if my insurance company denies payment.
- It is my responsibility to obtain physician referrals if my insurance requires one. If a referral is not obtained, but treatment is provided and the insurance company denies payment, it is my responsibility to make payment for the outstanding charges.
- I understand that some insurance companies have timely filing limits in reference to submission of medical claims. **I understand that information in regards to correct insurance policies must be given to the office within that time frame or I, as the patient, am solely responsible.**

My signature below indicates that I understand the information explained above. I acknowledge my financial responsibility for all charges including all reasonable costs, expenses in pursuing collection of such charges.

_____ _____

Signature of Patient or Legal Guardian Date