Patient Financial Responsibility

Patient's Name: _____ Date: _____

As a patient of Jacob Zamstein, MD, LLC, 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 Jacob Zamstein, MD, LLC 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 needed. If a referral is not obtained, but treatment is provided as an emergency and the insurance company denies payment, it is my responsibility to make payment for any outstanding charges.*
- *The office bills my insurance company for all visits, office procedures and laboratory fees performed IN office. Any questions related to outside bills should be directed to whoever provided the services.*
- *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, including court and attorney's fees incurred in pursuing collection of such charges.

_____ _____

Signature of patient or legal guardian *Date*