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Patient Acknowledgement

Park Avenue Radiologists, PC has verified that the following procedure:

Procedure(s): _____

CPT: _____

Scheduled for: ____/____/____

- Not covered by your insurance policy _____
initial
- Is not authorized by your insurance plan _____
initial
- Has not been pre-certified by your insurance plan _____
initial

I _____, have read and initialed as indicated above and I acknowledge that I am solely responsible for payment for this service. I understand that payment -in- full is required at time of service and that a bill will not be submitted to my insurance company on my behalf. Should I or the policyholder submit a claim to an insurance company and payment of the claim is denied, I will not hold Park Avenue Radiologists, PC responsible.

Patient Signature

____/____/____
Date

FOR OFFICE USE ONLY					
_____	____/____/____				
Carmen Abaya	Date				
Payment:	<input type="radio"/> Cash	<input type="radio"/> Check	<input type="radio"/> Visa/Mastercard	<input type="radio"/> Discover	<input type="radio"/> Amex