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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					