5507 South Congress Avenue, Suite 140
Atlantis, FL 33462
561-965-6685 (P), 561-965-8525 (F)

Insurance Consent Form

Every effort will be made by this office to verify your insurance; but you are responsible to know your benefits.

Insurance Disclaimer:
"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service".

Laboratory/Diagnostic charges: All blood work will be sent to your participating laboratory; we are not responsible for any charges that are incurred or not covered by your insurance.

Insurance Liability for Payment:
Your health insurance company will only pay for services that it determines to be "reasonable and necessary" Every effort will be made by this office to have all services and procedures pre authorized by your health insurance company. If your health insurance company determines that a particular service is not covered under the plan, your insurer will deny payment for those services.

Beneficiary Agreement:
I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

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Signature of Patient of Person Authorized to consent for patient Date

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Name of Patient of Person Authorized to consent for patient