

Acknowledgment of Responsibility to Pay

Uzzi Reiss, M. D., is not a provider for any insurance company, nor is he affiliated with any health provider group. All payments are due from you at the time services are rendered. Uzzi Reiss, M.D., will not bill insurance payors. However, he will provide you with an itemized statement for you to present to your insurance carrier, if you wish. In addition to his office consultation visit fee, you will also be charged for specific services such as blood or urine tests, ultrasound, office surgical supplies and procedures, blood drawing and handling, and in-hospital services. You are invited to ask our staff about specific charges before the service is provided.

A cancellation fee of \$350 will be charged to your credit card if you do not give us a 24-hour cancellation notice, or if you do not show up for your scheduled appointment.

Visa / MasterCard / Amex No.: _____ Exp. _____

Name as it exactly appears on card: _____ Signature: _____

I hereby authorize Uzzi Reiss, M.D., Inc. to disclose all or part of my medical records to my insurance carrier. I hereby grant Uzzi Reiss, M.D., Inc. permission to obtain personal credit reports on me in case I fail to pay for services rendered in a timely manner. I have been advised that I have the right to receive a copy of this authorization.

I acknowledge that I have read carefully, and that I understand and agree with all the terms above. Furthermore, I understand and agree that I am personally responsible for payment in full for all the charges in connection with medical services rendered to me by Uzzi Reiss, M.D., Inc., regardless of any insurance which might cover such charges.

Date: _____ Signature: _____

We must get this form **ONE MONTH** before your appointment by fax or mail.
If not received on time we will cancel your appointment.