Capital District & Colon Rectal surgery associates, P.C.

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Gennaro A. Daniels, MD
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PATIENT NAME ____

We appreciate the confidence you have shown in choosing us to provide for your health care needs.

You are responsible to provide us with correct insurance information at the time you are seen. If you fail to do so, or provide us with incorrect information, you will be responsible for any charges that are not paid.

You are also responsible for any co-pay, co-insurance, or deductibles required by your insurance company. You are responsible to know how much your co-pay is and pay at the time service is rendered. You are also required to obtain a referral from your primary care physician if your insurance requires one. You will receive a bill for any services deemed by insurance contract to be the patient responsibility.

If a referral is required, and you do not have one at the time of service, you will be financially responsible for the services you receive.

There may be services that are not covered under your particular insurance contract. If you elect to have these services, you will be responsible for the fees incurred. Depending on the procedure planned, you may have to pay a percentage of the cost up-front.

I have read the above policy regarding my financial responsibility for services provided to me or the above named patient. I certify that the insurance information is to the best of my knowledge true and accurate.

Patient Signature ____ Date ___________
Guarantor Signature ______________________________________ Date ___________

(if the guarantor is not the patient)

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