

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

I agree to provide **JOSEPH L. BACOTTI, JR.M.D.,P.C.** with:

- Accurate and prompt information concerning my health insurance plan
- Prompt notification, if any changes in my insurance plan or coverage occur  
During my course of treatment at **JOSEPH L BACOTTI, JR.M.D.,P.C.**

**I understand that I am financially responsible for any services, which are not covered by my insurance plan.**

I also acknowledge that I will be financially responsible, in accordance with any subscriber contract and **JOSEPH L. BACOTTI, JR. M.D.,P.C.** plan participation contract:

- If any insurance plan denies payment because I fail to comply with its procedures,  
or
- If I provide incorrect information which causes a delay in submitting the claim, or
- If I fail to bring any referral forms or other documents which my insurance plan requires.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date