CARLOS A. ORTIZ M.D. P.C.

142-42A 41 Avenue Flushing, NY 11355
T: 718-939-8440 F: 718-939-5378
NPI 1902972979 LIC 186079

Patient Name: _____ Date: _____

Patient Acct#: _____

INSURANCE WAIVER ACKNOWLEDGEMENT

Dear Patient,

Due to the rising cost of healthcare and the minimum reimbursement from insurance companies, you will be responsible for the charges that are not covered by your insurance company. Some charges are considered, but at less than the doctor's cost, therefore, you will be responsible for the difference, all other charges not payable will be charged in full. These charges are payable at the time of service. Please sign below that you acknowledge and accept this waiver and responsibility.

_____ _____

Patient/Responsible Party Signature Date