Eileen C Comia, M.D. LLC
35 Jolley Drive Suite no.102 Bloomfield, CT 06002
Tel (860)242-2200 Fax (860)242-2212

INSURANCE WAIVER

1. I understand that my health insurance is a contract between myself and the insurance company.

2. I understand the benefits of my health insurance plan. **I KNOW WHAT MY INSURANCE PAYS AND DOES NOT PAY FOR.**

3. I am certain that Dr. Comia participates in my health insurance plan.

4. **I HAVE INFORMED MY INSURANCE COMPANY THAT DR. COMIA IS MY PRIMARY CARE PHYSICIAN.**

5. I am aware that **COPAYS ARE DUE AT THE TIME OF VISIT.**

6. It is my responsibility to bring and show my health insurance card to the physician's office during each visit**. I UNDERSTAND THAT IF I FAIL TO BRING MY INSURANCE CARD, I WILL BE HELD RESPONSIBLE FOR THE VISIT.**

7. If, for any reason, my health insurance plan does not cover all or some of the charges incurred from services rendered, **I WILL BE HELD PERSONALLY RESPONSIBLE FOR PAYING THE BALANCE OF THE FULL AMOUNT OF CHARGES.**

8. I understand that **MEDICARE** only pays for services that it determines to be "reasonable and necessary" according to the Medicare Program. I also understand that Medicare may not pay for certain tests and procedures ordered by the physician. **I FULLY UNDERSTAND THAT IF THE SERVICE/S IS/ARE DENIED FOR PAYMENT BY MEDICARE, I THE PATIENT (OR THE UNDERSIGNED GUARDIAN) AGREES TO BE RESPONSIBLE FOR FULL PAYMENT OF SUCH SERVICES.**

9. **IF MY ACCOUNT IF REFERRED FOR COLLECTION, I AGREE TO PAY FOR THE LEGAL AND COLLECTION EXPENSES INCLUDING ATTORNEY'S FEES.**

I have read, understood, and agree with the information presented in this Insurance Waiver.

Name of Patient: _____

Signature of patient: _____ Date Signed: _____

Name of Guardian: _____

Signature of Guardian: _____ Date Signed: _____