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 plan pays for and what it does not pay for.**

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

4. I have informed my health insurance carrier that my primary care physician is Dr. Eileen Comia.

5. I am aware that copays are due for payment 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 information, I will be held responsible for the visit until I furnish a copy of the card.**

7. If, for any reason, my health insurance plan does not cover all or some of the charges incurred from services rendered, **I understand that I will be held personally responsible for paying the balance or 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 also fully understand that if the service/s is/are denied for payment by Medicare, I, the patient (or undersigned guardian) agrees to be responsible for full payment of such services.**

9. **If my account is 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: __ / __ / ____