

Jennifer Sartori, DPM, PLLC
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603-431-6070
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Insurance and financial liability:

Your insurance company provides coverage for medically necessary services for its members. However, your insurance company does not cover any services without a valid referral from the correct primary care physician, or if you have provided incorrect, outdated or invalid insurance information to us.

Your signature below indicates that you agree to assume financial responsibility for any and all services if a valid referral from the correct primary care physician is not received by our office within five (5) business days from the date(s) of service or if valid insurance information has not been provided. This is to include any and all family members.

It is your responsibility to cover all costs that your insurance plan does not cover. If you default on your account you will be held responsible for all court costs.

Cancellation notice must be provided at least **24 hours** in advance of your appointment, missed appointments or appointments not cancelled in that time period will be **billed to you** at the rate of \$ 25.00.

Authorization to pay benefits:

I authorize payment of medical benefits to Jennifer Sartori, DPM, PLLC for services rendered to me by this office.

Information release:

I authorize Dr. Sartori's office to release any information acquired in the course of taking the medical history, the medical examination or treatment, to my primary care doctor's office and for insurance claim filing.

The above is to remain in force until rescinded in writing by the undersigned:

Signature: _____

Printed name: _____ Date: _____

"Please complete the section below only if you ARE NOT the primary subscriber to your insurance. Thank you!"

<u>Insurance</u>	<u>Primary</u>	<u>Secondary</u>
Subscriber name:	_____	_____
Subscriber birth date:	_____	_____
Subscriber employer:	_____	_____
Subscriber SS #:	_____	_____