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FINANCIAL RESPONSIBILITY

Dear Patient Name:

Dr. Gindi provides what he feels is the best care that is appropriate for your health maintenance or health condition. This letter is to inform you that although these services are important for maintaining or assuring your optimum health, they may not be covered by your insurance company.

Your carrier may use the terms “medically necessary”, “routine”, “not covered” or “preventive care” to deny coverage for certain services including routine physicals,
pre-operative clearance, injections/vaccines, HIV screening, and others. Furthermore, carriers may claim to cover “routine care”, but this may not be as comprehensive as you expect.

Currently, there is no consistency among the multitude of carriers with respect to covered services. Unfortunately, our office staff cannot keep up with which carriers cover which services. Although we can help you by corresponding with your carrier to appeal improperly denied claims, we cannot predict the outcome of claims review. You may want to check with your carrier prior to being seen to verify that coverage is available for expected services.

Also, some of the specialized laboratory services will require that we use an outside lab. Please be advised that these tests may or may not be a covered expense from your insurance plan. We will provide your insurance information to them and they will bill you directly for any portion your insurance has not paid.

()___ I acknowledge that I have been informed regarding the use of an “outside lab” for Cedars-Sinai, Quest Diagnostics, Prometheus, True Health, RDL and Myriad Labs
and will be financially responsible for any or all charges.

Your signature verifies that you understand that services provided may not be covered by your policy and that you are financially responsible for these services even if deemed unnecessary or non-payable by your carrier.

Thank you.

Signature: ______________________________________   Report Date