Floral Park Ophthalmology, P.C.

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PATIENT RESPONSIBILITY OF PAYMENT AUTHORIZATION

Date:_____

I, _____ am fully aware that I am responsible to confirm that Dr. Lawrence F. Jindra is a participating physician in my insurance plan and to obtain any necessary referrals. I will pay any balance owed as a result of my insurance denying coverage or failing to make a payment.

_____
Patient Signature