MANAGED CARE RESPONSIBILITY ACKNOWLEDGEMENT

I,___________________________________understand that
(Patient or Guardian) (Please Print)

if my insurance requires any referral or authorizations, it is my responsibility to obtain these PRIOR TO EACH visit to D. Neal Mastruserio, M.D., LLC.

I am aware that if I do not have a referral at the time of my appointment, I will be responsible for the entire amount of my visit when services are rendered.

D. Neal Mastruserio, M.D., LLC is not responsible for obtaining managed care referrals; this is the patient's responsibility.

Date________________________________

Signature____________________________

Witness_____________________________