CPI PHYSICIANS, PC
Dr. Abul Azad, MD, MPH, FCCP
319 S. Manning Blvd – Suite 116 * Albany, NY 12208

FINANCIAL WAIVER FORM

To Our Patients:

This practice participates with many different insurance companies and their various plans. We try to keep up with the terms of each, but this is not always possible. If you are a member of a Managed Care Plan, or an Insurance Plan requiring a referral, you should be aware that most of these plans require your Primary Care Provider to provide prior authorization for specialist visits. If you do not personally request this, please check with someone at our front desk before being seen by the doctor to make sure that we have obtained authorization for you to be seen at this practice.

If no authorization has been obtained prior to your being seen, your insurance company will **NOT** cover the charges for today's visit and you will be responsible for them. Even if authorization is obtained, a Managed Care Plan has the ability to deny payment at a later date, claiming that the procedure is non-covered or not medically necessary. Any insurance plan may deny payment after telling us that it should be covered. This might be because of an error, or exclusion in the policy, or because of a change in your policy between the time the appointment was confirmed and the time it was carried out. It is also possible for them to determine that your coverage is no long valid on the date that the appointment is performed.

Should any of these unforeseen occurrences take place, you will become responsible for the charges involved regardless of what we may have estimated your responsibility to be. Because of the increasing number of insurance companies requiring this type of form to be filed, we ask that you sign the following statement before being seen at this office:

I have read the above statements and understand them and my responsibilities with respect to membership in a Managed Care Program (if applicable). I also understand my financial responsibilities with respect to paying all charges not covered by my insurance company for any reason (not to exceed the allowable fee as determined by my insurance company). I waive my rights to insurance benefits if I have not accurately informed you of my insurance coverage prior to my treatment.

Please note that CPI Physicians does not accept Wellcare Insurance!

_____ DATE: _____
NAME OF PATIENT: PLEASE PRINT CLEARLY

_____ _____
SIGNATURE OF PATIENT OFFICE STAFF WITNESS