

ANTHONY C. QUARTELL, M.D. & ASSOCIATES
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Doctor's Name: _____ Today's Date: _____

You may or may not be covered by your insurance company for today's visit depending on whether you meet the company guidelines. Some of these guidelines include, but are not limited to, one annual check-up per year (most insurance companies require this to be exactly 365 days and will not cover more than one routine exam during that time), HPV testing, Chlamydia and gonorrhea testing for patients who are sexually active and are under the age of 25, biopsies sent out, ALL lab work such as blood tests, pap smears, etc, as well as referrals for ultrasounds, to other physicians and to other facilities. Because all insurance company rules differ and are constantly changing, it is up to you as the subscriber to be aware of any reasons for possible denials, including whether the services are considered to be in or out of network. If you are in doubt we strongly suggest that you contact your insurance carrier prior to services being rendered to confirm that the services will be covered. Otherwise, you may receive a bill from those providers.

In addition, should you require unexpected additional services performed by one of our providers on the same day as your scheduled visit, there may be an extra co-pay charged by your insurance carrier depending how they process your claim.

_____ I understand that I am liable for all balances for any services, whether charged directly by Anthony C. Quartell, MD & Associates or another outside provider in connection with today's visit or future visits, not covered by my insurance company.

_____ I choose not to have the HPV testing at this time. I have been informed of the importance of having this test performed.

_____ I am under the age of 25 and I choose not to have the Chlamydia & Gonorrhea testing at this time. I have been informed of the importance of having this test performed.

_____ I have Cigna insurance coverage and I am aware that they will not cover ultrasounds performed in this office, however; I am aware that I am liable for the entire balance.

Patient Name

Patient's Signature and Date