Celina M. Nadelman, M.D.
Fine Needle Aspiration Specialist
Fast, Accurate, Compassionate: A Superior Way to Biopsy

Date: _____ **Patient's Name**: _____

Insurance ID: _____ **Insurance Plan**: _____

Physician: CELINA M. NADELMAN, MD - Lab Director

INSURANCE ACKNOWLEDGEMENT

Please be aware that Dr. Nadelman may not be a contracted provider with your insurance. However, we will submit a claim for services rendered in our office to your insurance plan as a courtesy to our patients. Even though we may not participate in your insurance plan, it is usually possible to work out an acceptable financial arrangement. It is the responsibility of you, the patient, to pay the balance for services rendered, within a reasonable time.
Please feel free to contact our office at 310.702.6701 to discuss these arrangements.

3RD PARTY FEES

Occasionally, additional studies are needed to be performed during your visit. Some of the FNA sample that was obtained may be sent to a reference laboratory (a specialized laboratory, not our laboratory, Precision Aspiration and Biopsy) for this additional testing. Please note that third party laboratories may require additional costs at you, the patient's, expense. The amount of these charges are completely separate from Dr. Nadelman's services and Precision Aspiration and Biopsy and are unknown.

CREDIT CARD AUTHORIZATION

By my signature below, I, _____, authorize Precision Aspiration
Patient Full Name
and Biopsy and its Billing Agents, to make charges to my credit or debit card for **any remaining balance not billable/payable** by my insurance carrier for services provided, or any remaining self paying balance. I will be notified in advance of these charges occurring, and may receive a copy of the receipt at my request.

Name as it appears on card: _____ _____ _____
First name MI Last name

Type of Card (circle): MasterCard VISA AMEX DISC

Card#: _____ _____ _____ _____ CVV: _____

Expiration Date: : _____/_____/ 20_____

Zip code where billing statements for this card are sent: _____

I authorize Precision Aspiration and Biopsy to securely store this credit/debit card information and charge it as listed above.

Signature: _____ Date: _____/_____/ 20_____

In addition to me, this card may be used for the following people:

_____

I have read and understand this information.

_____ _____
Patient's Name Patient's Signature