Rosemary Delgado M.D.

Acknowledgment of Receipt of and Agreement with the Office and Financial Policy

I have read, and I understand the handout, ***Office and Financial Policies.***

I authorize the physicians of Rosemary Delgado M.D to furnish all necessary information to my insurance carrier(s) concerning my medical care and treatment. I also irrevocable assign to Rosemary Delgado, M.D all insurance payments for services rendered and all major medical benefits.

I understand that I am personally obligated to pay for all medical services rendered regardless of whether or how much my insurance company has paid.

By signing below, I am stating that I understand, and I agree to the above policies.

NAME: _____ DATE: _____

SIGNATURE: _____