Insurance Waiver

I acknowledge and authorize MARIO G. SILVESTRI, DPM, to deliver, teach, administer or perform as necessary, the product and treatment prescribed by my physician. I authorize MARIO G. SILVESTRI, DPM to submit a claim(s) for services to my insurer on my behalf and I authorize MARIO G. SILVESTRI, DPM to release any of my medical information required by my insurer to process the claim(s). I understand that I am responsible for, and I agree to pay, any portion of the amount due for such services not pain by my insurance carrier when resulting from deductibles, co-pays, coinsurance or amount due as patient responsibility.

Patient or Guarantor Signature: _____

Relationship to Patient:_____

NO SHOW POLICY

In the event that you are unable to keep your appointment with this office, it is imperative that you call to cancel and/or reschedule your appointment. Any patient that does not keep his/her appointment and has not called to cancel, will be charged a $25.00 FEE. You will not be permitted to schedule an additional appointment until this fee is paid. This policy is necessary to ensure that patients needing appointments can get them in a timely manner. We thank you for yur cooperation with regard to the aforesaid. Should you have any questions please contact the office manager.

Patient Signature:_____