Mark L. Meyer, M.D., F.A.C.C
110 East 59th Street, Suite 9B
New York, NY 10022
Tel: 212-583-2999

Notice of Financial Responsibility

I, the undersigned, give my authorization to treat and assign directly to Mark L. Meyer, MD, PLLC, all medical benefits, if any, otherwise payable to me for services rendered.

I understand that I am ultimately financially responsible for all in network and out-of-network services provided to me by the physician or any physician that he may refer me to for additional services. **I also understand that it is my responsibility to obtain a referral in advance, if needed. Otherwise, I will be responsible for this balance.**

I hereby authorize the doctor to release all information necessary to secure payment of benefits.

I authorize the use of this signature on all my insurance submissions. I understand that payment is expected at the time of service.

Name (Print): ____

Signature: ____

Date: ____