

NASSIF E. SOUEID, MD FACS

PLASTIC SURGERY

**7505 Osler Drive
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I HEREBY ACKNOWLEDGE MY INSURANCE MAY REQUIRE ME TO HAVE A REFERRAL FROM MY PRIMARY CARE PHYSICIAN IN ORDER TO SEE A SPECIALIST.

IF I DO NOT HAVE A REFERRAL AND STILL WISH TO BE SEEN, I HEREBY ACCEPT FULL FINANCIAL RESPONSIBILITY FOR ANY AND ALL SERVICES RENDERED BY DR. NASSIF E. SOUEID.

MY INSURANCE MAY DEEM SERVICES NOT MEDICALLY NECCESARY. I AM FINANCIALLY RESPONSIBLE FOR ANY AND ALL SERVICES NOT COVERED BY MY INSURANCE.

IN ADDITION, IF I HAVE A CO-PAY AND **DO NOT PAY** IT AT THE TIME OF MY VISIT, I UNDERSTAND THRE WILL BE AN \$8.00 SERVICE FEE APPLIED TO MY ACCOUNT WHICH I WILL PAY IN ADDTION TO MY COPAY WHEN BILLED.

SIGNATURE

DATE