Susan L Zito DO MPH FACR FACOI

CHANGE OF INSURANCE

Patient Name______________________________________ DOB:_____________

SUBSCRIBER Name _______________________________ DOB:_____________
(if applicable)

I have changed my health insurance to the following:

Primary Insurance Name ____

Member ID Number ____

Secondary Insurance Name ____
(if applicable)

Member ID Number ____

Please read and initial the following:

_______ Payment for services is expected at the time of visit

_______ If insurance if filed, I authorize benefits to be paid directly to Suncoast Rheumatology

_______ I am responsible for the balance on my account, regardless of my insurance coverage

_______ I understand it is my responsibility that my insurance is up-to-date with my doctor's staff and the billing service.

By signing below, you are acknowledging that you are responsible for all co-insurance, deductibles, referrals and outstanding balances on your account. If you fail to adhere to the above, we reserve the right to cancel or deny service until your account is up to date.

Patient Name______________________________________ DOB:_____________

Signature ____ Date:_____________

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