Syracuse Plastic Surgery
3107 East Genesee St
Syracuse, NY 13224
Phone (315)299-5313 Fax (315)299-5661

Financial Responsibility for Services

Date_____

Patient Name_____

Date of Service_____

Service Provided_____

Dear Patient,

Syracuse Plastic Surgery will submit a request to your insurance company carrier for financial reimbursement for services provided to you.

In the event that your insurance carrier denies payment and any co-insurance you have does not cover these services your signature below confirms that you agree to be personally and fully responsible for all costs associated with the services provided to you.

Thank You,
Syracuse Plastic Surgery

I understand I will be personally and fully responsible for all costs associated with any services provided to me that **are not covered** by my insurance carrier.

X_____

Patient Signature