

**MALEK MEDICAL CENTER
SHERIF MALEK, MD
232 NORWOOD AVENUE
WEST LONG BRANCH, NJ 07764
TEL (732)222-6637 fax (732)222-6645**

**NOTICE OF ACCEPTANCE OF RESPONSIBILITY FOR REFERRALS
AND PRIOR-AUTHORIZATIONS**

Patient's Name: _____

Responsible Party (if different from the patient): _____

I, (the patient or the responsible party on behalf of the patient) understand and agree to the following:

- 1- My medical insurance coverage is pursuant to a contract between myself and my insurance company. I am responsible for understanding my rights and responsibilities under my medical insurance policy, for understanding what procedures are covered or not, and for understanding the general policies of my insurance contract as they pertain to me.
- 2- Some medical procedures, tests or services may not be covered by my medical insurance policy. It is my responsibility to inquire with my insurance company to determine whether any procedure or test ordered by Malek Medical Center is a covered item under my plan, and if so, to what extent. I understand that I am fully responsible for all uncovered procedures, tests and services, or any portion thereof not covered by my insurance company.
- 3- My insurance company may require that I obtain a referral or a prior-authorization from Malek Medical Center, for certain procedures, tests or services, I understand that informing the front desk staff and obtaining such a referral or prior-authorization is my responsibility. I further understand that the referral and approved prior-authorization forms must be obtained before going for that procedure, test or service.
- 4- I accept full responsibility for the consequences of not obtaining necessary referrals and/ or prior authorizations at the time for my appointment. I agree to pay all charges for services rendered to me by Malek Medical Center, including charges for non covered procedures by my insurance plan for any reason, including for lack of a referral and/ or prior-authorization.

Patient/ responsible party's signature: _____

Office staff signature: _____ **Date:** _____