



**PALM BEACH
SPORTSMEDICINE**
AND ORTHOPAEDIC CENTER, P.A.

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Physical Medicine & Rehabilitation

Dear Valued Patient: _____,

You would be surprised to know how many people do not know what kind of benefits they have with their Insurance Companies.

As a courtesy to you, we will bill your Insurance Company for services rendered by our Office. However, if for any reason, we are unable to collect reimbursement, all monies owed will become your responsibility.

We will attempt to get the most benefit from your Insurance Company, however, we will need your assistance. Please supply us with your most recent information and make us aware should changes arise in your policy. Prior to your next appointment, please contact your Insurance Company to be sure that we are on your Plan, and that your coverage is current. **THIS IS YOUR RESPONSIBILITY, NOT OURS!!!!!!!!!!!!!!**

Please be aware that all co-payments and deductibles are due at the time of service.

By signing below, you are stating that you understand this important component of our Office Policy.

As always, thank you for choosing PALM BEACH SPORTSMEDICINE for your Orthopaedic needs.

Estimated patient benefits: _____

SIGNATURE

DATE