GADI AVSHALOMOV, M.D
2084 East 67th Street
Brooklyn, New York 11234
Phone: 718 444 8014
Fax: 718 444 8068

Date: _____

Patient: _____

Responsible Party : _____

This letter is to confirm that the insurance (_____) I, _____ have provided is the only form of insurance coverage for myself/my child ,_____ .

I am aware that any other form of coverage must be presented on the date of service in order to avoid future charges.

I have been notified by the staff member(s) of Dr.Gadi Avshalomovs' office that if I have other insurance which is not presented, I will be responsible for payment of all services privately.

_____
Signature of responsible party