Gina Del Giudice, M.D.

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Patient Name: ______________________________

Date of Service: ______________________________

BENEFICIARY AGREEMENT

I HAVE BEEN NOTIFIED BY THE STAFF THAT IN THE EVENT THE SERVICES PERFORMED TODAY ARE NOT COVERED BY MY INSURANCE, I AGREE TO BE PERSONALLY AND FULLY RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF SERVICE. THIS IS ALSO TRUE IF I DO NOT HAVE ANY INSURANCE COVERAGE.

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Signed **Date**