Rheumatology Center of Princeton
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Gina Del Giudice, M.D., FACR, FACP
Michael J. Froncek, M.D., MS, FACP, FACR

BENEFICIARY AGREEMENT

Patient Name: _____

Date of Service: _____

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.

_____ _____

Signature of Patient Date