

**Poolesville Family Practice is NOT
Contracted with your Insurance Company**

Date: _____

Patient Name: _____

Patient's Insurance (primary): _____

I understand that Dr. Duggirala is not contracted with my insurance company. I realize that my bill would probably be lower if I were to go to a doctor contracted with my insurance. I do understand that I am ultimately responsible for the payment of my bill. I understand that the office may submit my bill to my insurance company, but I agree to be responsible for any portion of my bill which is not covered by my insurance.

Signature (Patient or Responsible Party): _____

Name of financially responsible party (if different from patient):
