

Panacea Wellness Studio
17 North Country Road
Port Jefferson, NY 11777
Tel: (631) 509-4270

This form must be signed by all NYSHIP Patients

Date: _____

Patient Name: _____

Insurance Co: NYSHIP _____

Patient ID #: _____

Dear Patient:

Based on our experience with your insurance company, our payment for services rendered to you will be sent directly to you (the patient) instead of this office. If you receive any type of correspondence from the above named insurance company for services rendered in this office, please bring the information to us as soon as possible and do not deposit the check without speaking to us first.

STATEMENT OF AGREEMENT:

I, _____ (patient name) hereby agree to endorse any checks received by me from the above named insurance company for services rendered in this office or I will deposit the check and immediately reimburse this office.

Patient Signature

Date

Print Patient Name

Patient Phone Number