

SISSELMAN MEDICAL GROUP, PC
Stephen G. Sisselman, D.O., F.A.C.P.
Jill Sisselman, D.O., F.A.A.F.P

100 Veterans Boulevard
Suite 2
Massapequa, NY 11758
516-308-4040 -- tel
516-804-3684 -- fax

2171 Jericho Turnpike
Suite 135
Commack, NY 11725
631-670-6525-tel
631-670-6526-fax

I, _____ have been informed on this
date _____ by Sisselman Medical Group that if my health plan does not
cover routine physicals, any type of surgery or any vaccines that I have been given, I will
be personally responsible for the charges incurred and in the event of non-payment, I
would be responsible for any fees incurred in an attempt to collect the balance.
I understand that Sisselman Medical Group will bill my insurance company on my
behalf.

Patient or Responsible Party Signature

SISSELMAN MEDICAL GROUP, PC

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100 Veterans Boulevard, Suite 2
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SERVICE FEE AGREEMENT FOR NOT CANCELLING
APPOINTMENT

I, _____ AM AWARE THAT IF I
HAVE AN APPOINTMENT SCHEDULED AT SISSELMAN
MEDICAL GROUP AND I AM UNABLE TO KEEP THIS
APPOINTMENT, I WILL BE CHARGED A SERVICE FEE OF
\$20.00 IF I DO NOT CALL TO CANCEL WITHIN 24 HOURS.

I UNDERSTAND THAT BY NOT CALLING TO CANCEL MY
APPOINTMENT, I AM HOLDING AN APPOINTMENT IN THE
DOCTORS SCHEDULE THAT ANOTHER PATIENT COULD USE.

PATIENT NAME

PATIENT SIGNATURE

DATE _____