

Acknowledgement of Receipt of Notice

CT. GASTROENTEROLOGY ASSOCIATES, PC
1000 Asylum Ave, Suite 3212, Hartford, CT 06105

Tel. 860-522-1171

I hereby acknowledge that I received a copy of this medical practice's
Notice of No Surprise Billing Policy..

Name of Patient _____

I hereby acknowledge that I received a copy of this medical practice's Notice of No Surprise Billing Policy and that I may request a copy of any amended No Surprise Billing Policy at each appointment.

Yes No (circle one) I would like to receive a copy of any amended No Surprise Billing Policy by e-mail at: _____.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate your relationship to the patient:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient

Name of Patient: _____

For Office Use Only:

Signed form received by: _____

Acknowledgment refused:

Efforts to obtain:

Reasons for refusal:
