Allison J. Scharf, DC

INSURANCE ASSIGNMENT POLICY STATEMENT

Patient:

You have selected "INSURANCE ASSIGNMENT" as the method of choice to take care of your financial obligation with this office.

It is important that you realize that in this office we offer the option of "INSURANCE ASSIGNMENT" strictly as a courtesy to our patients, and as such our patients must understand and agree to the following:

1. That you are considered a cash patient until, you bring in any necessary insurance forms and your insurance card for us to obtain a copy, and this office qualifies and accepts your coverage.

2. That you are ultimately responsible for full payment of any and all services rendered.

3. That you must pay all deductible in full.

4. That co-insurance or co-payment must be paid at the time of service or at the end of each and every week.

5. That if your carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim and that after 90 days you will be responsible for payment in full of any outstanding balance.

6. That in the event you discontinue your program of care prior to the doctor's consent, you are responsible for payment in full of any outstanding balance and the courtesy of insurance assignment is immediately discontinued.

This insurance assignment policy must be followed and we ask that you sign this form as acknowledgement that our policy was explained to you, that you understand it and that you accept full responsibility.

Patient's Name _____ Date_____

Patient's Signature _____

Parent/Guardian Signature _____
(If patient is a minor)

Witness _____