Robert M. Scharf, M.D.

HIPAA and FINANCIAL ACKNOWLEDGEMENT

I, ______________________________ (patient), acknowledge that I have received a copy of Robert M. Scharf, M.D.'s (the practice's) Notice Regarding Privacy of Personal Health Information (HIPAA), Version 9-12-07.

____________________________ Date: ________________
(Signature)

FINANCIAL ASSIGNMENT AND RELEASE

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policies.

Payment for services not covered by your insurance plan is due at the time of service. We accept checks (Valid Driver's License Required), cash, money orders, and debit cards. MasterCard, Visa, Discover and American Express are also welcome. We will be happy to file your insurance if we are listed as a "Participating Provider" of your plan. You must realize, however, that:

- Your insurance is a contract between you, the employer and the insurance company. We are not a party to that contract and are not responsible for knowing the specific benefits of your plan.
- We will file your insurance on plans with which we participate only if we have a current copy of your insurance card and all pertinent information required for filing claims.
- If we are unable to verify benefits for a same day procedure, you will be asked to self-pay or reschedule. If you choose to self-pay, we will file for the procedure and upon receipt of the insurance explanation of benefits, if a credit balance exists, we will refund you within 15 business days.

- **I understand that I am financially responsible for "non-covered benefits," such as being measured for new glasses. Some plans include glasses measurements as a covered service. Others do not. If you ask for this service and your plan does not cover it, you will be responsible for payment for that service even if the Explanation of Benefits (EOB) states that you are not responsible.**

We must emphasize that the filing of claims is a courtesy that we extend to our patients. All charges are your responsibility from the date services are rendered. It is understood that temporary financial problems may effect timely payment of your account. If such problems arise, please contact us promptly for assistance in the management of your account. If you have any questions regarding the above information, please do not hesitate to ask.

1. I hereby authorize payment directly to **Robert M. Scharf, M.D.** all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges incurred, including refraction, specialized testing and all other services rendered on my behalf or for my dependents, whether or not these services are paid for by insurance.

2. I authorize **Robert M. Scharf, M.D.** and/or any other provider or supplier in the office of **Robert M. Scharf, M.D.** to release any information required to secure the payments of benefits or to provide for necessary medical services for me or my dependents.

3. I authorize the use of my signature on all insurance submissions.

SIGNED ____ Date __________________