Andrew C. Elgort, Ed.D., Inc.
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Charlottesville, VA 22911
434.987.2759

Summary of Financial Responsibility

Payment for services is due at the time the service is rendered unless other arrangements are made. Insurance is billed as a service to my patients. Having an authorization for services is not a guarantee that the insurance company will pay.

Please review and initial the following. Your initials signify that you have read and understood your responsibilities.

_____ I understand that I am fully and totally responsible for payment of all fees.

_____ I understand that my insurance may be filed for me, but that reimbursement of any fees is between my insurance company and me based on my specific policy. I understand that any reimbursement payment from my insurance company to be made directly to back to me.

_____ I authorize the release of information required to process insurance claims (e.g., treatment plans) required by insurance companies.

_____ I understand that if preauthorization for services is necessary by my insurance policy, I am fully responsible to obtain the needed pre-authorization for services.

_____ I understand that I am responsible for notifying Dr. Elgort of any changes to my insurance, my address, my phone number, or my employment.

_____ I understand that most insurance companies only reimburse for face-to-face services and that Dr. Elgort will only submit a claim for those services.

_____ I understand that I may be billed full fee for missed appointments unless I gave notice of my inability to attend the appointment at least 24 hours prior to the time of the appointment.

_____ I have read and understood the Informed Consent for Services documnt, especially regarding Professional Fees, Billing and Payments, and Insurance Reimbursement.

____ ________________
Signature of Patient or Parent/Guardian of Minor Date