Lancaster Medical
4893 Transit Road
Depew, NY 14043
www.lancaster-medical.com

PATIENT TREATMENT WAIVER

I,

____

(Print Name)

Understand that the physician I am seeing
today **cannot verify my insurance coverage,**
and therefore I am responsible for paying the bill
if I continue with the visit today.

If there is a discrepancy with my insurance coverage
through my employer or such, I understand it is my
responsibility to resolve the problem and advise the
Lancaster Medical billing office @
(716) 608-7040 within 30 days so my claim can
be submitted to my insurance co. within the allotted
time frame. Otherwise I understand I will be responsible to
pay the bill myself.

____

(Signature)

____

(Provider, please print)

____

(Date)

This form is valid only for the date indicated