Financial Waiver Form

Patient Name:_____

Today's Date: 03/31/22

☐ **Self Pay (Without Insurance)** : I acknowledge that I do not have insurance and have elected to be seen as a self pay patient. I am agreeing to assume all financial responsibility and will pay for all services at the time of service, unless other arrangements have been made. This agreement will remain in effect unless proof of insurance is provided at a subsequent date.

☐ **Referral Required**: I acknowledge that my insurance company requires an authorization/referral for today's visit. This is required to be obtained before today's visit. If this was not obtained, I understand that I am financially responsible for today's visit, and any other unauthorized future visits, in the event my insurance carrier does not pay for today's visit.

My Primary Care Provider is :_____

☐ **Medicaid or Other Out of Network Coverage**: I acknowledge that my insurance company does not include this practice in their network and they may not cover services rendered for today's visit. I acknowledge that I have been informed my insurance is not accepted and will pay for all services at the time of visit.

☐ **Proof of Insurance**: I have active insurance coverage but cannot provide my insurance information at today's visit. I acknowledge I may assume full financial responsibility for my visit today, and all future visits, unless an insurance card is presented within 30 days of the visit.

My Insurance carrier is :_____

☐ **Active Coverage Decline to Bill:** I have active insurance coverage but opt to be self pay for today's visit. I acknowledge today's visit will not be billed to insurance.

All questions regarding my individual financial situation, described above, has been answered. I understand that I am financially responsible for the applicable visit(s) as described above.

Patient/Parent Signature: