Acknowledgment of Financial Responsibility (Waiver) for Non-Covered In-Network Services & Office-only Services Provided by an Out-of-Network Provider

Trinity Health

IHA Medical Group

Location Date of Service

Patient Name Date of Birth Guarantor Name

In-Network – ***I understand that even if my provider is in network with my health coverage, service(s) provided to me may or may not be paid by my insurance company for any of the following reasons:***

- Services may not be covered or payable by my insurance carrier:
  - Additional Problems Addressed During a Preventive Visit/Wellness visit
  - After Hours Fee
  - Counseling
  - Employer or Sports Physicals
  - Frequency Insurance Limitations
  - Laboratory; Pathology; Imaging or Screening Tests
  - *Screening versus Diagnostic (Problem Focused) testing: Depending on the reason your test was ordered; this could be processed under your screening or diagnostic benefits and may result in patient responsibility.*
  - *COVID-19 testing/screening*
  - Some Preventive Services
  - Telehealth Services
- Required insurance information, authorizations, referrals, pre-certifications or any other requirements of my insurance company have not been obtained.
- My insurance coverage cannot be verified at this time; OR, Insurance carrier's demographic information is wrong or does not match IHA records; OR, Newborn not added to policy.
- I am assigned to a different PCP.
- VFC:
  - I elect to waive participation with the VFC Program
  - I choose to enroll with the VFC Program and I agree to pay the administration fees
- I elect to pay for the services without notifying my health coverage (Self-Pay).
- DME Supplies: DME supplies are self-pay only. DME sales are final, no returns or exchanges.
- Other:

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Continued on other side.

Out of Network –

☐ PLEASE INITIAL

I have been advised to seek an in-network provider. State and federal law provide protections that limit the amount I will be required to pay for certain emergency services, services in a facility and other services if I am not first advised that my provider is out of network. If permitted by applicable law, I agree to pay out of pocket costs that could be higher than if I were to have services from an "in network" provider. *I agree that I have been advised that the service(s) I am requesting and that will be provided to me will be considered out of network and may or may not be paid by my health coverage/ insurance company*.

Services: _____

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Your health benefit plan may or may not provide coverage for all of the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan. The nonparticipating provider must provide a good faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided. You also have a right to request that the health care services be performed by a provider that participates with your health benefit plan, and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the health care services that you need.

☐ PLEASE INITIAL

Good Faith Estimate Provided - By signing below, I acknowledge that I have received, read, and understand the out of network disclosure and good faith estimate.

I understand that if permitted by applicable law I will be financially responsible for payment of all services provided that are not paid by my insurance company or that I have chosen to self-pay.

_____

Patient Signature Date

_____

Parent or Legal Guardian Signature Relationship to Patient Date

_____

(Type or print name of patient or patient's representative)