

## Insurance Waiver for NON-COVERED SERVICES & NO REFERRAL

### PATIENT INFORMATION

PATIENT's NAME: «PName»

ADDRESS: \_\_\_\_\_

BIRTHDATE: «PDOB»                      DAYTIME TELEPHONE NUMBER: \_\_\_\_\_

SOCIAL SECURITY NO: \_\_\_\_\_ INSURANCE: \_\_\_\_\_

### NON-COVERED SERVICES AND INSURANCE REFERRAL

**NON COVERED SERVICES**

I understand that my insurance will only pay for services and supplies that it determines are covered benefits under my particular plan and medically necessary for my care and treatment. I have been informed by Women's Care Florida - North Florida Ob-Gyn that the following service or supply:

\_\_\_\_\_

\_\_\_\_\_

is or may be a Non-Covered Service under my insurance plan.

I desire to have the service or supply provided with the understanding that the charge(s) will not be filed with my insurance, or if the charges are filed and my insurance company denies payment, **I will be financially responsible for the total cost of the service.**

Women's Care Florida – North Florida Ob-Gyn will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, procedure or pregnancy, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance.

**NO REFERRAL**

I understand as **I do not have a referral for today's visit**, I will be seen as a "**Private Pay**" patient today and will be asked to pay in advance for today's visit. I understand and agree neither the provider nor I will file a claim for the service provided at today's visit.

### SIGNATURE

Date: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Parent, Guardian or Legal Representative Signature: \_\_\_\_\_

Witness Signature: \_\_\_\_\_