Acknowledgment of Financial Responsibility for the Cost of Services

This form with be retained with your medical records.

WASHINGTON INSTITUTE ORTHOPEDIC CENTER

Service:

I have been informed that my health care benefits insurer or administrator may determine that this procedure is an investigational service and may not be a covered benefit or considered medically. Therefore, the service could potentially be excluded from coverage by my healthcare plan. I have received counseling on the potential adverse reactions related to this service and have had the opportunity to have my questions answered to my satisfaction. My provider has also informed me about alternative treatments, if any, that may be covered by my insurance carrier.

I understand that my provider may request that my insurance carrier reconsider a non-coverage determination by presenting evidence that the referenced service is not an investigational service, is a covered service and that the service should be considered to be medically necessary or medically appropriate. I also understand that I have the right to request that my carrier reconsider a non-coverage determination, as described in the member grievance section of my healthcare benefits plan, either before or after receiving the service.

I have been informed that the cost of this service will be $. I understand that I will pay this amount at the time of service. I understand that I may seek reimbursement from my insurance carrier through my own efforts.

In the event of multiple procedures, this form is valid for one (1) unit of the prescribed service, unless specifically stated otherwise.

Date:

Patient Name (print):

Patient Signature*:
*or of Legal Financially Responsible Person to Patient

*Relationship of Legal:
Financially Responsible Person to Patient

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