

FINANCIAL RESPONSIBILITY STATEMENT

Non-Covered Services

The physician's office may seek payment from patients for services not covered by your insurance. The staff must inform you prior to treatment that the procedure/treatment may not be a covered service.



Initial

_____ I understand that the treatment received today may not be a covered service by my insurance.

_____ I acknowledge that I have no record of my insurance coverage and may be financially responsible for today's visit.

_____ I understand that I have no insurance coverage and will be financially responsible for today's visit.

Patient Signature

Date

Signature (Parent/Guardian)

Date

Witness

Date

