Patient Label

HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by Lone Tree Surgery Center, LLC. Iunderstand that benefits cannot be guaranteed until a claim is paid. I further understand I may be responsible for all charges incurred today ***even if I elect to have my insurance billed first.***

Estimate of Lone Tree Surgery Center, LLC. Charges:

CPT/HCPC	Description	Estimated Charge

This is only an estimate and may not be the full financial responsibility.

I acknowledge that my insurance may not cover the services listed for the following reason:

_ My provider is not a participating provider with my insurance plan.

_ The service(s) listed may not be covered by my insurance plan.

_ The appropriate authorization/referral required by my insurance plan has not/was not able to be obtained.

I am electing the following action for my charges:

_ I wish to have my insurance billed first. I understand I will be financially responsible for any charges that are not covered by my insurance.

_ I am electing NOT to have these charges billed to my insurance company. I understand no claim will be generated by Lone Tree Surgery Center, LLC. for these services. I will remit payment for service in full today.

____
Name of patient (printed)

____
Name of witness (printed)

____
Signature of patient or legally authorized representative

____
Signature of witness

____
Relationship to patient (if applicable)

____
Date/Time

_________(Initial) Directed by Patient/Legal Representative to sign on patient's behalf, after reading document to him/her.

Reason for directed signature____

Discussion interpreted by:

____ ____

Language **Operator# or Interpreter name**

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Date/Time