Acknowledgement of Patient Financial Responsibility

Patient Name: _____ Date: _____

I have been informed that my health care insurance, _____, may not pay for the service listed below as defined in my Member Health Care Benefits Plan. Therefore, the service would be excluded from coverage from my insurance company and will not be paid for by my insurance.

My provider has informed me about alternative treatments, if any, that may be covered by my insurance. I understand that I will be responsible for the full cost of this service as referenced below, and I have still elected to have the services performed.

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

This form will expire and will no longer be valid six (6) months from the date above.

Procedure	Estimated Cost	Reason Your Insurance May Not Pay
	$	☐ Your insurance does not pay for this service ☐ Your insurance does not pay for this service for your condition ☐ Your insurance does not pay for this service this frequently ☐ This is an excluded service on your specific insurance plan ☐ Your insurance considers this service to be investigational ☐ Your insurance considers this service to be cosmetic ☐ Other: _____

Additional Information:

There is an additional $66 administration injection fee added to all injection prices listed above, and if elected to receive the service, you will be responsible for full payment on the injection fee

There is an additional $9 venipuncture fee added to any lab work prices listed above, and if elected to receive the service, you will be responsible for full payment on the venipuncture

Notifier: FSRWM
2001 Laurel Ave # 201
Knoxvile, TN 37916

Patient/Guardian Signature: _____

Date: _____