

Acknowledgment of Financial Responsibility (Waiver) for Non-Covered In-Network Services & Office-only Services Provided by an Out-of-Network Provider / Notice to Uninsured & Self-Pay Regarding Right to Receive a Good Faith Estimate

SECTION 1

Location		Date of Service
Patient Name	Date of Birth	Guarantor Name

In-Network

I understand that even if my provider is in network with my health coverage, service(s) provided to me may or may not be paid by my insurance company for any of the following reasons:

- Authorizations, referrals, pre-certifications are not a guarantee of payment
- My insurance coverage cannot be verified at this time (i.e. Insurance closed)
- Insurance carrier's demographic information is wrong or does not match IHA records
- Coordination of benefits issue identified by my insurance company
- Newborn not added to policy
- I am assigned to a different PCP
- VFC:
 - I elect to waive participation with the VFC Program
 - I choose to enroll with the VFC Program, and I agree to pay the administration fees
- DME Supplies are self-pay only. DME sales are final, no returns or exchanges

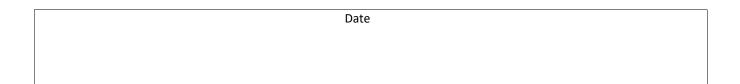
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		State law provides protections for in-office services provided out of network if I am not first advised that my provider is out of network. I have been advised to seek an in-network provider. State and
EAS	SF	federal law provide protections that limit the amount I will be required to pay for emergency services and certain services in a facility or related to a facility visit.
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If permitted by applicable law, I agree to pay out of pocket costs that could be higher than if I were to have services from an "in network" provider.

Services: _					
Out of Netw	ork Disclaimer				
you are	scheduled to receive or the	nay not provide coverage for all of the had not providers providing those services. Nervices that are not covered by your head	ou may be		
participa services	ites with your health bene	efit plan, and may contact your carrier to r cost and to receive information on in-r	ne health care services be performed by a provider to an, and may contact your carrier to arrange for those and to receive information on in-network providers nat you need.		
services are reas	to be provided. This God onably expected for your	nust provide a good faith estimate of the cost of the health c sood Faith Estimate shows the costs of items and services the our health care needs for an item or service. The estimate is the time the estimate was created.			
circumstances/costs that may a care services provided. You cou		not include any unforeseen, unknown or unexpected arise during treatment which may affect the cost of the healt uld be charged more if complications or special circumstantal aw allows you to dispute (appeal) the bill.			
	od Faith Estimate does no provider.	ot obligate or require you to obtain any o	of the listed servic		
understan understan	d the out of network discl d that if permitted by app	signing below, I acknowledge that I had losure above and have received a good licable law I will be financially responsib by my health coverage/plan or that I ha	faith estimate. I ble for payment of		
nt Signature			Date		
t or Legal Gua	rdian Signature	Relationship to patient	Date		
-					
or print name	of patient or patient's rep	resentative)			

PLEASE INITIAL



FEB 2022

No Surprises Act Self-Pay Good Faith Estimate Notice

If you are **uninsured** or **choosing to self-pay** for the health care services you're receiving, you have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give patients who don't have certain types of health care coverage or who are not using certain types of health care coverage an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least \$400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1800-985-3059.