Cotton O'Neil

901 S.W. Garfield Ave., Topeka, KS 66606 • 785-354-9591

Patient Name: **MRN:**

PATIENT WAIVER

NOTE: If your insurance doesn't pay for the service below, you may have to pay.

Your insurance does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your insurance may not pay for the service below.

Service:	Estimated Cost:	Reason Your Insurance May Not Pay:
☐ _____ ☐ _____ ☐ _____	☐ _____ ☐ _____ ☐ _____	☐ Your Insurance does not pay for these tests for your condition. ☐ Your Insurance does not pay for these tests as often as this. ☐ Your Insurance does not pay for experimental or research use tests. ☐ Your Insurance is out of network. ☐ Other _____

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the service listed above.

  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your insurance cannot require us to do this.

OPTIONS: Check only one box. We cannot choose a box for you.

❑**OPTION 1.** I want the service listed above. You may ask to be paid now, but I also want my insurance billed for an official decision on payment. I understand that if my insurance doesn't pay, I am responsible for payment. If my insurance does pay, you will refund any payments I made to you, less co-pays or deductibles.

❑**OPTION 2.** I want the service listed above, but do not bill my insurance. You may ask to be paid now as I am responsible for payment.

❑**OPTION 3.** I don't want the service listed above. I understand with this choice I am **not** responsible for payment.

Additional Information:

Signing below means that you have received and understand this notice. You also receive a copy.

Signature:	Date: