PATIENT HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by the University Physicians, Inc. I understand I may be responsible for all charges incurred today for (service/cpt code) chromosomal microarray (81229) by (provider) Dr. Karen Swisshelm or Dr. Mary Haag, even if I elect to have my insurance billed first. Estimate of UPI charges $1,506.00 (this is only an estimate and may not be the full financial responsibility).

- The **provider** performing the above services or therapies is not a participating provider with my health insurance. Therefore these services/therapies are not covered by my policy.
  - _____Bill insurance
  - _____Do not bill insurance (Elective Self Pay)

- The **scope of services** rendered by this **provider** may not be covered by my health insurance policy.
  - _____Bill insurance
  - _____Do not bill insurance (Elective Self Pay)

- The appropriate **authorization** required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician.
  - _____Bill insurance
  - _____Do not bill insurance (Elective Self Pay)

- No claim will be sent to my insurance since it is my personal decision not to use my health insurance benefits for the above service/therapy even though I understand that these services/therapies are considered covered by my policy. (Elective Self Pay)

Patient Signature (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)

______________________________

Printed Name and Relationship of Person Authorized to Sign for Patient:

______________________________

Reason Patient is Unable to Sign

Insurance Waiver Explained by: ________________________________

(Printed Name of Hospital or UPI Representative)

Signature of Hospital or UPI Representative

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Date 11/24/03