PATIENT HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by CU Medicine. I understand I may be responsible for all charges incurred today for chromosomal microarray (CPT code 81402, 81403, 81404, 81405, 81407, 81408, or 81479) by (provider) Dr. Liming Bao, Dr. Karen Swisshelm, or Dr. Mary Haag, **even if I elect to have my insurance billed first.**

Estimate of CU Medicine charges $371.40 (**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 form)

___________________________     _______________________
Printed Name and Relationship of Person Authorized to Sign for Patient     Date

Reason Patient is Unable to Sign

☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

Insurance Waiver Explained by: ______________________________

(Printed Name of Hospital or CU Medicine Representative)

___________________________     _______________________
Signature of Hospital or CU Medicine Representative     Date