



2700000

PLACE LABEL HERE.  
  
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

**INSURANCE WAIVER & STATEMENT OF RESPONSIBILITY FORM**

Health Care Professional Providing Service \_\_\_\_\_

Department \_\_\_\_\_ Date(s) of Service \_\_\_\_\_

Describe Service \_\_\_\_\_

**\*PLEASE CHECK THE APPROPRIATE BOX BELOW:**

**WAIVER: Use For Contracted Plans Only**

- Services Requiring a Referral**  
I understand that my health insurance plan requires that I must have a referral from my primary care physician (PCP) before seeking specialty care. Since I do not have a referral from my PCP, I understand that depending on my health insurance plan, I am either financially responsible for an increased amount or for the entire amount of the service(s) being provided today and agree to pay the University of Virginia Health Services Foundation and/or the University of Virginia Medical Center.
- Services Beyond the Referral**  
I am requesting to have service(s) provided which are beyond those specified in my referral. Since I am requesting to have service(s) provided which are beyond those specified in my referral, I understand that depending on my health insurance plan, I am either financially responsible for an increased amount or for the entire amount of the service(s) being provided today and agree to pay the University of Virginia Health Services Foundation and/or the University of Virginia Medical Center.
- Non Covered Services**  
I understand that the service(s) being provided may not be covered by my health insurance plan or the preauthorization has been denied by my insurance plan, and that I am financially responsible for possibly the entire cost of the service(s) being provided today and agree to pay the University of Virginia Health Services Foundation and/or the University Medical Center the entire amount.

**STATEMENT OF RESPONSIBILITY: Assignment of Benefits**

- Non-Participating Health Plan: University of Virginia Medical Center ("Medical Center") and/or University of Virginia Health Services Foundation (the "Foundation") Providers**  
I understand that the Medical Center facility and/or health care providers of the Foundation are not participating under my health plan. Consequently, I understand that any payment made by my health plan for covered services provided to me by the Medical Center and/or Foundation may be directed to me and NOT to the Medical Center and/or Foundation. When my health plan issues a check directly to me in payment of the charges submitted to my health plan by Medical Center and/or Foundation for the services provided, I understand that these funds are provided to me for the purpose of paying the Medical Center and/or Foundation for the services provided to me. I agree to make full payment of these funds to the Medical Center and/or Foundation within fifteen (15) days of the date I receive the funds from my health plan.

**STATEMENT OF RESPONSIBILITY: Financial**

- In consideration for services furnished, or to be furnished, I guarantee payment to the University of Virginia Medical Center and the University of Virginia Health Services Foundation of all outstanding balances incurred or to be incurred, including those not paid by any third party source. If payment is not made when due, I agree to pay all reasonable costs and expenses related to collection of any outstanding balances including but not limited to reasonable attorneys' fees.

**This form has been explained to me. I have been given the opportunity to ask questions, my questions have been answered to my satisfaction, and I do understand my financial responsibility. I agree to be legally bound by the terms of this Insurance Waiver & Statement of Responsibility Form.**

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PATIENT NAME (Print): \_\_\_\_\_

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

(If patient under 18 years old)

PARENT/GUARDIAN NAME (Print): \_\_\_\_\_

SIGNATURE OF PERSON PRESENTING FORM: \_\_\_\_\_ DATE: \_\_\_\_\_

White - HIS Yellow - Patient Pink - Department