

**UNIVERSITY OF KANSAS PHYSICIANS PATIENT RESPONSIBILITY FOR
PAYMENT WAIVER FORM**

I understand that I am financially responsible for all services received on _____ because:

(CHECK ONE):

_____ I have not provided my insurance information. If insurance information and verification of my eligibility is provided within the time restrictions for filing claims to my insurance companies, my insurance will be billed. In the event my insurance coverage is not effective, or the timely filing limit has passed, I agree to be financially responsible for services rendered today. If my failure to provide insurance information today results in non-payment or reduced payment from my insurance carrier(s) for services requiring pre-authorization, charges for these services may also become my financial responsibility.

I am providing insurance information to:

Department: _____

Contact: _____

Phone: _____

_____ I have provided my new insurance card(s) and after my eligibility and benefits are verified, my insurance will be filed. In the event that my insurance denies or requires prior authorization, I agree to be financially responsible for the services rendered today.

_____ I have elected to visit a specialist and receive specialty services without a referral from my primary care physician.

_____ The services being performed today are not a covered benefit under my insurance plan.

_____ I do not have insurance and agree to be financially responsible for services rendered today.

Patient Print Name: _____ DOB: _____

Patient or Guardian Signature: _____ Date: _____