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WAIVER OF INSURANCE LIABILITY

I will personally accept the financial responsibility for this visit, and will pay directly to Women Ob/Gyn, P.A. any and all fees related to this office visit.

Initial whichever applies (check one):

_____ I understand that my insurance is **IN-NETWORK** and that my health insurer may not pay for some or all of the services received from Women Ob/Gyn, P.A. for reasons including, but not limited to, the requirement of a referral or pre-authorization. If my insurance rejects payment for services I agree and understand that I am responsible for payment in full within 30 days of receipt of a bill for services provided.

_____ I understand that my insurance is **OUT-OF-NETWORK**. I agree to pay in full for services received, and I am solely responsible for payment of those charges. I understand if I have an HMO product for which Women Ob/Gyn is Out of Network, neither I nor this medical practice may receive reimbursement from insurance and that my obligation to pay HMO premium is unaffected.

_____ I do not have health insurance and I will pay the costs of today's visit at the time of service.

_____ I have **MEDICARE**, my **MEDICARE** opt out form as been signed.

_____ I was unable to present a valid insurance card at the time of today's services and will pay in full for services rendered today. My payment will be deposited unless I deliver a valid card for which Women Ob/Gyn is in-network before the office closes today. If I don't deliver a valid card to Women Ob/Gyn today, I understand I will receive a credit (if appropriate) after insurance payment has been received by Women Ob/Gyn.

_____ I understand Women Ob/Gyn is not a participating or a authorized **TRICARE** provider and I am responsible for payment of services in full even if the amount is above the 115% limit above the **TRICARE** fee schedule allowed by law. I voluntarily waive my balance billing protection which federal law allows. I understand that I am free to seek care from a **TRICARE** contracted provider. I understand that **TRICARE** may deny me reimbursement for services provided services provided by Women Ob/Gyn. I have been given a copy of the waiver. I am not an active duty member.

Continue->>

Patient Signature **Today's Date (MM/DD/YYYY)**