Office of Family Nurse Practitioner Laura Hudson FNP-C
835 Central Ave. Suite 200 Dover, NH 03820 Phone: 603-749-0001

LIABILITY WAIVER

Please fill out the following, initial the appropriate lines and sign the bottom of this form

Primary Care Provider's information is required for proper billing of all claims

☐ **Check if your PCP is Laura Hudson FNP-C** otherwise list you PCP's info below

PCP's Name: ________________________________ **Practice Name:**_____________________________

PCP's City/State: ______________________________**Office Phone:** ______________________________

GENERAL INFORMATION & INSURANCE WAIVER OF LIABILITY

_______Most medical insurance companies have high deductibles and highly variable and changing rules and restrictions about specific visits, labs, radiology studies, medications and procedures. It is impossible for us to verify if we are in your network, what your particular plan covers or when you have met your deductible or even if a visit will or will not apply to your deductible. It is ***YOUR*** responsibility to learn / know what tests are covered, what lab, medical or radiology groups are in your network, and if your insurance covers only routine or only problem care and. It is ***YOUR*** responsibility to discuss this information with your provider while testing is being ordered, and accept any costs that are billed to you by our office or the labs / facilities that process your testing. It is expected that you will be able to pay ***YOUR*** copay, co-insurance or previous balance upon arrival to an appointment. It is ***YOUR*** responsibility to pay your bill in full; and as a courtesy you we bill your insurance on your behalf if we are participating with that company. By signing this Waiver of Liability, you agree to be personally responsible to pay any balances acquired from services at this office in a timely manner, whether fees for services received have not been covered by your insurance company due to: Deductible not being met; Non-covered Benefit on your policy; or Not in Network or any other reason not due to fault of ours.

HMO WAIVER OF LIABILITY

_______I understand that if my insurance is or becomes an HMO Insurance policy, it is **required for me to obtain a referral** from the Primary Care Provider (PCP) my insurance has listed on file and present it **prior to** or **at the time** services are rendered at this office. This is for **any type of visit**, including routine yearly check-up or problem visits. If I do not have a referral on file at the time services are provided, I agree to be personally responsible to pay the full amount of charges for all routine and problem care, devices, studies, tests and procedures. If this practice is your PCP office this does not apply. If you require an insurance referral from us, we request that you provide us with 1 week notice prior to any appointment or procedure requiring a referral and that when you contact us for the referral you provide us with the location, name and NPI of the provider you will be seeing, and for what reason.

MEDICARE WAIVER OF LIABILITY

_______Notice: Medicare will only pay for services that are determined to be "reasonable and medically necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare Program standards, Medicare will deny payment for that service. Be advised that Medicare is ***likely to deny payment for*** preventive exams, some lab tests, pap smears, some radiology studies, medications, equipment, and some procedures. By signing this form I agree that if I have Medicare insurance and they deny payment, I agree to personally be fully responsible for the full amount for such services.

Patient Name ____ DOB ____________________

Signature Patient / Guardian ____________________________________ Date ____________________

Print Name of signer if not patient _______________________________ Relationship_______________