



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 Compass Family Health otherwise list your 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 of 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. 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 any previous balance upon arrival to an appointment. It is **YOUR** responsibility to pay your bill in full; and as a courtesy to you we bill your insurance on your behalf if we are participating with that company. You must keep us up to date of changes in insurance and make sure your insurance has your correct information. If a claim is denied due to your lack of keeping your insurance company up to date, you will be responsible for any bill which might be declined. 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 service 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, device 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

I understand that if I were to have Medicare insurance, they 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 _____