PATIENT DEMOGRAPHICS

PATIENT HEALTH INSURANCE WAIVER

I have requested services and/or therapies provided by the University Physicians, Inc. I understand I may be responsible for all charges incurred today for (service/CPT code) targeted chromosomal microarray (CPT Code 81479) by Dr. Liming Bao, Dr. Karen Swisshelm, Dr. Mary Haag or Dr. Meng Su, even if I elect to have my insurance billed first.

Estimate of UPI charges \$457.80 (this is only an estimate and may not be the full financial responsibility).

☐ The provider performing the above services or therapies is not a participating pro											g provi	der with	n my		
							services/therapies are not covered by my policyDo not bill insurance (Elective Self Pay)							,	
	The scope of services rendered by this provider may not be covered by my health insurance policy.													Э	
	Bill insurance					Do not bill insurance (Elective Self Pay)									
	The appropriate authorization required by my health insurance policy has not been obtained from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician. Bill insuranceDo not bill insurance (Elective Self Pay)														
0	No claim will be sent to my insurance since it is my personal decision not to use my health insurance benefits for the above service/therapy even though I understand that these services/therapies are considered covered by my policy. (Elective Self Pay)														
Patient Signature (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)															
			ationship Patient:	of Pers	on	_		Date					_		
Reaso	n Patien	t is Una	ble to Sig	jn											
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Insurance Waiver Explained by:															
(Printed Name of Hospital or UPI Representative)															
Signature of Hospital or UPI Representative								Date			-		/24/03		
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yellow-UPI pink-clinic white-patient