UNIVERSITY PHYSICIANS, INC.

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) chromosomal microarray (81229) by (provider) Dr. Liming Bao, Dr. Karen Swisshelm, or Dr. Mary Haag, ***even if I elect to have my insurance billed first.***

Estimate of UPI charges $1,551.00 (**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 provider** with my health insurance. Therefore these services/therapies are not covered by my policy.
_____Bill insurance ____Do not bill insurance (Elective Self Pay)

❒ The **scope of services** rendered by this **provider** may not be covered by my health insurance policy.
_____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 insurance ____Do not bill insurance (Elective Self Pay)

❒ 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)

_____ **Date** _____

Printed Name and Relationship of Person Authorized to Sign for Patient:

_____

Reason Patient is Unable to Sign

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Insurance Waiver Explained by: _____
(Printed Name of Hospital or UPI Representative)

_____ _____

Signature of Hospital or UPI Representative **Date**

11/24/03