KANSAS UNIVERSITY PHYSICIANS, INC.
PATIENT RESPONSIBILITY FOR PAYMENT WAIVER FORM

I understand that I am financially responsible for all services received on _____ because:

(Check one):

_____I have not provided my insurance information. If insurance information and verification of my eligibility is provided within the time restrictions for filing claims to my insurance companies, my insurance will be billed. In the event my insurance coverage is not effective, or the timely filing limit has passed, I agree to be financially responsible for services rendered today**. If my failure to provide insurance information today results in non-payment or reduced payment from my insurance carrier(s) for services requiring pre-authorization, charges for these services may also become my financial responsibility.**

University of Kansas Physicians Central Billing Office

1-877-729-5874

The billing office is open Mon-Fri 8:30a-5p CST

_____ I have provided my new insurance card(s) and after my eligibility and benefits are verified, my insurance will be filed. **In the event that my insurance denies or reduces payment or requires prior authorization, I agree to be financially responsible for the services rendered today.**

_____I have elected to visit a specialist and receive specialty services without a referral from my primary care physician. **If my failure to provide a referral results in non-payment or reduced payment from my insurance carrier(s) charges for these services may also become my financial responsibility.**

_____The services being performed today are not a covered benefit under my insurance plan. **I understand that charges for these services are my financial responsibility.**

_____I have agreed to be classified as a self-pay patient; therefore no insurance will be billed. As a result, I have paid a down payment of $_____. **I understand this does not pay for my entire bill, and I will be billed for the additional amount due.**

_____ _____
Patient Name (Printed) Patient Acct. Number

_____ _____
Patient Signature (or Guardian if Minor) Medical Record Number

_____
Date