UCLA Health

MRN:
Patient Name:

(Patient Label)

ACKNOWLEDGEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Dear Patient,

Due to increasing complexity in the healthcare industry, it is important for us to understand the precise nature of your doctor visit today. Identifying services and properly coding the visit will allow your insurance company to properly allocate financial responsibility. Also, we want you to know what to expect so that you can make an informed decision.

Some insurance companies will allow us to provide preventive, wellness, routine, or annual services at the same time we address a new and/or chronic medical problem(s). However, some insurance companies will not allow this. Please help us determine how to best manage your healthcare needs today by reviewing the following options, and then make the most appropriate selection.

I am visiting the doctor today:

- ☐ For my annual physical (preventive) examination only. I will not discuss a new or chronic medical problem(s) with the doctor today.
- ☐ To only discuss a new and/or chronic medical problem(s) (problem oriented service only).
- ☐ For my annual physical (preventive) examination AND to discuss a new and/or chronic medical problem(s) (problem oriented service).

NON-COVERED SERVICES

I am visiting the doctor today as indicated above. I acknowledge that **(1)** if I provide false information with regard to my insurance coverage, **(2)** if the services provided are not a covered benefit of my insurance plan, **(3)** if I am no longer covered by this, or any other insurance plan, **(4)** if I present any insurance card with outdated or inaccurate information or if I have an HMO insurance but am not a member of the UCLA Medical Group or **(5)** if insurance denies payment for any reason, I acknowledge that I will be responsible to pay the cost of the doctor office visit and all other charges related to the visit.

I am currently enrolled with the insurance carrier stated below:

Insurance Name: ____

You are responsible to inform us of any changes in coverage.

I understand that if I discuss both preventive and problem-oriented services during my doctor visit today, one portion will be billed as preventive and one portion will be billed as problem-oriented. I acknowledge that my insurance company may or may not pay for both of these services and I will be responsible for anything my insurance does not cover.

Print Patient Name ________________________

Patient or Representative Signature ___________________________ Date ________ Time _______

If signed by someone other than the patient, please specify relationship to the patient: ___________

Your signature is valid for one year from today's date

You may set up another appointment to address issues that you elect no to address during today's visit.