Member Acknowledgement of Financial Responsibility

Patient Services

Patient Name: ________________________________ MRN: ____________________

Date of Service: ________________________________ Provider: ________________

Insurance: ____________________________ Assigned Medical Group: ______________

Service, device, supply or equipment in question: ________________________________

Dear Patient,

Your health plan will only reimburse Riverside Medical Clinic for services, devices, supplies or equipment if the patient is eligible at the time of service and the services provided are a covered benefit and are medically necessary. In addition, your policy could also have an exclusion which limits coverage related to specific services. The specifics of your benefits and coverage are outlined in the Evidence of Coverage manual sent to the subscriber at the time of enrollment.

Your health plan requires Riverside Medical Clinic to notify you when a service, device, supply or equipment may not be covered, could be deemed not medically necessary, is excluded or the patient's eligibility cannot be verified.

Your signature below acknowledges that a Riverside Medical Clinic staff member has notified you that one or more of the following may be applicable under the terms of your health plan coverage. Where applicable you will be held financially responsible to reimburse Riverside Medical Clinic for the following service(s), device, supply and/or equipment or the health plan requires a higher copayment or patient out of pocket responsibility:

_____ Cosmetic Service

_____ Non-Covered Service, Supply, Device or Equipment

_____ Diagnosis (reason for visit) could be excluded or result in a higher out of pocket to the patient

_____ A copay or higher out of pocket could be accessed.

_____ Prior - Authorization has not been obtained, patient elected to proceed with service

_____ Eligibility could not be verified and/or obtained at the time of service.

Riverside Medical Clinic cannot assume financial responsibility or risk for what your coverage or benefits exclude and are deemed patient responsibility.

______________________________ Date: ________________

Member or Legal Representative (please print)

______________________________ Date: ________________

Signature of Member or Legal Respresentative

525-762 (2/16)