



Acknowledgement of Financial Responsibility for the Cost of Services

Date: _____

Provider: _____

Patient Name: _____ Date of Birth: _____

Prescribed Service/Procedure may include any individual one or multiple combination of the following:

PAP, Physician Interpretation of PAP if required, HPV if reflexed HPV CT (Chlamydia) NG (N. Gonorrhea)

I agree that I have been informed that my health care benefits insurer/administrator may not cover the above referenced service(s).

I agree that my provider explained to me that my health care benefits insurer/administrator may not cover the referenced service(s) because the service may not be considered medically necessary/appropriate or exceeds my plans benefit limits.

I understand the potential costs of the service(s) above will be about:

- \$64 PAP
- \$50 Physician Interpretation of PAP
- \$90 HPV
- \$75 CT (Chlamydia)
- \$75 NG (N. gonorrhea)

This form is applicable for only one of each service.

I understand that if I choose to get the service(s) and it's not covered by my health care benefits insurer/administrator, I will be responsible for all costs associated with the service(s). The above cost includes, but is not limited to, practitioner costs, facility costs, ancillary charges, and any other related expenses. I accept that my health care benefits insurer/administrator may not pay for the service(s).

I understand my provider, or an ancillary service provider may ask my health care benefits insurer/administrator to reconsider their decision. I also understand I can request reconsideration of that decision, per the member grievance section of my health plan, either before or after receiving the service(s).

Finally, I understand that this form is applicable for only one of each of the above referenced service or procedure. Also, this form is no longer valid as of six months from the date on this form.

Signature of Patient or Responsible Party

Relationship if Responsible Party

Date