ACKNOWLEGEMENT OF FINANCIAL RESPONSIBILITY

PATIENT NAME _____ DATE _____

REGISTRATION # _____ MEDICAL RECORD # _____

Welcome to Virtua Health. You are here to receive outpatient services requested by your physician. Depending upon the type of health insurance coverage you have and the requirements of your insurance plan, you may have a personal responsibility for all, part, or none of the cost of these outpatient services.

Most insurance plans (HMO's, managed care plans, indemnity plans, etc.) require you to obtain and present to us BEFORE services are rendered, a pre-authorization or referral form. If that is the case and you do not present this information to us, your insurance plan may not pay some of all of the cost of the services it would ordinarily pay on your behalf and it will be your personal responsibility to pay these costs. IT IS YOUR RESPONSIBILITY TO KNOW WHETHER YOUR INSURANCE PLAN REQUIRES YOU TO PROVIDE US WITH A PRE-AUTHORIZATION OR REFERRAL FORM OR CAPITATED SITE REQUIREMENTS.

Check all that apply	Patient Initials	
☐	_____	Virtua Health is not a participating provider for _____
☐	_____	Services have not been authorized
☐	_____	Release of medical information has not been signed
☐	_____	Medical necessity has not been determined
☐	_____	No Primary Care Physician referral
☐	_____	Patient requesting insurance billed for denial
☐	_____	Other (CAPITATED LAB / RADIOLOGY SITE FORMS) _____

If you cannot reach your physician's office to obtain the required pre-authorization or referral form or for any other reason, you have the following choices:

1. You may reschedule your appointment until such time as the required information is obtained; or
2. You may choose to receive the services at this time and attempt to have the required information delivered to us as soon as possible, but not later than three (3) business days from today.

PLEASE BE AWARE THAT IF YOU SELECT OPTION #2, YOUR INSURANCE PLAN MAY DECLINE TO PAY ALL OR PART OF THE COSTS IT WOULD HAVE PAID IF YOU HAD SELECTED OPTION #1. YOU WILL BE PERSONALLY RESPONSIBLE FOR THESE COSTS.

PLEASE INDICATE IF YOU SELECT OPTION #1 OR OPTION #2 BY CIRCLING YOUR CHOICE AND SIGNING YOUR NAME BELOW:

_____ _____

Signature of Patient / Legal Representative Virtua Health Representative