AGREEMENT OF FINANCIAL RESPONSIBILITY- MEDICAID

Patient Name Last, First, Mi	Date of Birth (Mo/Day/Yr)	Medicaid ID #

Section 1 (Provider completes this section)

Description of non-covered service(s), for which the patient agrees to accept financial responsibility:

_____

_____

Expected cost of non-covered service(s) $_____

Expected date of service_____/_____/_____

The provider of services,_____, certifies that this office has an established policy for billing all patients, for services not covered by a third party. In accordance with state Medicaid provider billing guidelines, the patient has been advised prior to services being rendered the specific non-covered services(s) to be provided and the expected cost.

Completed by (print)_____for the above provider.

Signature:_____Date_____

Section 2 (Patient or responsible party completes this section)

I am the patient or responsible party. I understand my health plan may not pay for the services described in Section 1. I have been told what the expected cost will be. I have been informed and have signed this agreement before receiving the described services. I have been told why I may be billed and agree to pay the bill as described in Section 1.

Signature of Patient or Responsible Party:_____Date_____

Responsible Party, if other than patient (print):_____

Relationship to Patient:_____