# FINANCIAL RESPONSIBILITY WAIVER

**INSURANCE AUTHORIZATION, VERIFICATION AND CO-PAYMENTS ARE THE RESPONSIBILITY OF THE MEMBER. I UNDERSTAND THAT IF MY INSURANCE BENEFITS AND/OR ELIGIBILITY ARE NOT APPROVED BY MY HEALTH PLAN OR INDEPENDENT PHYSICIANS ASSOCIATION THEN I AM FINANCIALLY RESPONSIBLE AND AGREE TO PAY FOR ALL CHARGES RELATED TO SERVICE PROVIDED BY THOMAS W. ELA M.D.**

I am selecting the following health plan option:

- ☐ HMO (Health Maintenance Organization) with Primary Care Physician/IPA authorization and co-pay as indicated on insurance card.
- ☐ POS (Point-of-Service) without prior Primary Care Physician/IPA authorization and with higher co-pay and/or deductible.
- ☐ PPO (Preferred Provider Organization) with appropriate co-pay, deductible and/or percentage of allowed charges.
- ☐ Indemnity plan or automobile insurance with deductible and/or percentage of allowed charges. NO LIENS ACCEPTED.
- ☐ Workers' Compensation as authorized by the insurance carrier.
- ☐ Medicare without HMO enrollment.
- ☐ HMO (Health Maintenance Organization) Self-referring with no authorization from Primary Care Physician/IPA. I understand and agree that I am financially responsible for this visit.

**PATIENT NAME:** ____________________

Signature of responsibility________________________ Date: ____________

THIS WAIVER WILL REMAIN VALID FROM THIS DAY FORWARD TO INCLUDE ALL FUTURE SERVICES, RELATED TO THIS PATIENT.