PATIENT LIABILITY STATEMENT

The undersigned acknowledges that he/she has been informed that the services rendered may not be covered by the insurance plan in which the patient participates. I understand that the insurance may not be filed if it meets one of the following criteria and that I will be held liable for all charges incurred:

1. **Physician does not participate with the said insurance plan. _____(insurance plan)**
2. **No authorization/referral for services. _____(insurance company)**
3. **Any non-covered services. _____(service/insurance**
4. **Insurance plan will not provide for the covering physician. _____(insurance plan/covering M.D.)**

The undersigned acknowledges that he/she has read the above and acknowledges that they understand their insurance may not be filed and they will be held liable for all charges incurred.

Witness	**Date**
Patient (print)	**Date**
Patient (signature)	**Date**
Responsible party (signature)	**Relationship** **Date**

If patient is under age of 18, the responsible party must sign.