UNC Hospitals · UNC Faculty Physicians

Notification of Patient Financial Liability

*<u>All</u> of the following information pertaining to the patient's visit **<u>must</u>** be completed. DO NOT use the card imprinter to complete this form.*

Patient Name_____

Medical Record Number _____**Account Number** _____

Date of Service_____**Name of Insurance Carrier**_____

Servicing Provider _____**Clinic/Service Location**_____

Treatment/Procedure_____

- I understand that UNC Hospitals and/or UNC Faculty Physicians will make every attempt to contact my insurance carrier to verify my benefits and obtain an insurance authorization for the above-referenced procedure.
- I further understand that an estimated deposit for services may be required prior to the above treatment or procedure being performed.
- I understand that I will be financially responsible for any out-of-pocket expenses not covered by my insurance carrier, even if my insurance company indicates that no prior authorization is required.
- If this service is not covered by my insurance carrier, or if the service is explicitly not authorized by my insurance carrier, I will be responsible for all fees associated with the service.
- If my insurance carrier has not responded to UNC Hospitals' and/or UNC Faculty Physicians' attempts to obtain prior authorization, I may be responsible for all fees associated with the service.

I understand that I have elected to receive medical care that my insurance carrier may not cover. In the event that services are not covered and/or not authorized, I understand all charges incurred will be my sole responsibility.

_____

Patient Signature *Date*

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Signature of Parent or Policy Holder if Patient is a Minor *Date*

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Signature of Witness (not related to Patient) *Date*