Document Type: ABN/WAIVER

CST034

METHODIST HEALTH SYSTEM

ALL FACILITIES OF METHODIST HEALTH SYSTEMS

MPC Patient Label

NAME:_____ DOB:_____

FIN:_____ MRN:_____

NON-MEDICARE WAIVER OF LIABILITY

Thank you for choosing the **Methodist Health System** as a partner in your healthcare. We are honored by your choice and we are committed to providing you with the highest quality healthcare. The decision regarding your medical care is one between you and your provider. Coverage of those services depends on your insurance plan. Before making any decisions about your medical care, please read your insurance coverage/benefit information carefully.

Type of Service: _____

Estimated Cost of Service:_____ Date of Service: _____

* This is an **estimate** of your out-of-pocket responsibility. The final bills may vary from the **estimate**, based on your medical condition, unknown circumstances or complications, final diagnosis and/or treatment(s).

Patient Responsibilities:

As a patient, it is important that you understand your insurance plan's benefits and coverage rules as well as your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit. If you have questions regarding your insurance plan's benefits, contact your plan's customer service department (the phone numbers are on your insurance card).

- You must report any changes in insurance coverage to the Methodist Health System staff or **Customer Service at 402-345-4230** promptly to avoid additional financial responsibility.
- You are responsible for payment of outstanding deductibles and co-insurance or co-payments at the time of service.
- **A Financial Counselor can be reached at: 402-354-4009 or 712-396-7547** if you have additional questions on your account or would like to make payment arrangements.

Patient Acknowledgment of Financial Responsibilities:

By signing below, I acknowledge that I have chosen to receive the above services. I understand and agree that I will be personally liable to pay for any and all medical treatment or diagnostic testing provided by any Methodist Health System provider in the event that my insurance plan denies either full or partial payment. Reasons for denial can include: not a covered service, cosmetic or investigative service or determined as not meeting medical necessity, as defined in my plan's benefits or coverage terms. I understand that this is an **estimate** only; my actual balance on final bills may vary.

_____
Patient Signature or Patient Representative

_____
Print Patient Name

_____
Relationship to Patient

_____
Date/Time

_____
Witness Signature

_____
Witness Print Name

☐ Electronically Signed

_____
Date/Time

Hospital Patient Label

NAME:_____ DOB:_____

FIN:_____ MRN:_____

PERMANENT PART OF MEDICAL RECORD

NONMCWAIVER
Rev 03/2020