NJUI NEW JERSEY UROLOGIC INSTITUTE

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CONSENT FOR FINANCIAL RESPONSIBILITY FOR UNREFERRED OR NON-COVERED SERVICES

Name:	Patient Account #:
Insurance Carrier:	
Type of Service:	Date of Service:

I understand that:

☐ A referral form from my Primary Care Physician is required for any and all non-emergency out-patient hospital/specialist services. I acknowledge that I do not have a referral form with me at this time, but I choose to receive services without the required referral. I understand that without the appropriate referral, I may be held responsible for some or all payments incurred for these services.

☐ I understand that this procedure may not be covered by my insurance carrier and I agree to be financially liable for any payments not covered by my insurance.

☐ I understand that urological equipment and supplies may not be covered by my insurance plan. I agree to be financially liable for charges incurred.

☐ I understand that certain services, such as urological tests, are not covered when performed in an office setting. If I choose to receive these services at the New Jersey Urologic Institute, rather than in a lab authorized by my insurance company, I agree to be financially liable for charges incurred.

☐ I understand that I will be responsible for all fees incurred for this visit or any other services my insurance coverage in not in effect on this date.

☐ I am a Medicaid/NJ Family Care beneficiary and have chosen to waive my benefits for today's Urologic service provided to me. I am choosing this option as the provider is not participating in the Medicaid Program or the requested service is a non-covered Medicaid / NJ Family Care services. I agree to pay the entire amount due today.

X	Witness:
Print Name:	
Date:	Date: