McLaren
MEDICAL GROUP

McLaren Medical Group

NOTICE OF FINANCIAL RESPONSIBILITY

Patient Name: _____ **Date of Birth: _____**

Date of Service: _____ **Insurance Carrier: _____**

Provider Name: _____

You are seeking treatment from this office and services may not be covered by your insurance for one or more of the following reasons. If you choose to receive services from this office, you will be expected to pay any amount not covered by your insurance.

_____ The services you are seeking may not be a covered benefit under your insurance

_____ You do not have a valid authorization on file for the services you are seeking

_____ This office does not participate with your insurance carrier

_____ Other: _____

Any questions regarding your insurance coverage should be directed to your insurance carrier.

Patient Agreement:

I have been notified that treatment at this office may not be covered by my insurance for the reason(s) stated above. I understand the explanation given. I agree to be personally and fully responsible for any amount not covered by my insurance.

_____ _____

Patient or Guardian Signature Date

_____

Witness