



**PATIENT HEALTH INSURANCE WAIVER**

I have requested services and/or therapies provided by a medical provider of the University of Colorado School of Medicine. I understand that these services and/or therapies will be billed by University Physicians, Inc. I further understand I may be responsible for all charges incurred today for (service/cpt code) \_\_\_\_\_ by (provider) \_\_\_\_\_ **even if I elect to have my insurance billed first.**

Estimate of UPI charges \_\_\_\_\_ **(this is only an estimate and may not be the full financial responsibility).**

<input type="checkbox"/>	The <b>provider</b> performing the above services or therapies is <b>not a participating provider</b> with my health insurance. Therefore these services/therapies are not covered by my policy. _____ Bill insurance _____ Do not bill insurance (Elective Self Pay)
<input type="checkbox"/>	The <b>scope of services</b> rendered by this <b>provider</b> may not be covered by my health insurance policy. _____ Bill insurance _____ Do not bill insurance (Elective Self Pay)
<input type="checkbox"/>	The appropriate <b>authorization</b> required by my health insurance policy <b>has not been obtained</b> from my primary care physician. It is my personal decision not to obtain the authorization from my primary care physician. _____ Bill insurance _____ Do not bill insurance (Elective Self Pay)
<input type="checkbox"/>	No claim will be sent to my insurance since it is my personal <b>decision not to use my health insurance</b> benefits for the above service/therapy even though I understand that these services/therapies are considered covered by my policy. (Elective Self Pay)

**Patient Signature** (or parent/guardian/other-authorized person if patient is a minor, mentally incompetent, or physically unable to sign this form)

\_\_\_\_\_  
**Printed Name and Relationship of Person  
Authorized to Sign for Patient**

\_\_\_\_\_  
**Date**

**Reason Patient is Unable to Sign**

\_\_\_\_\_

**Insurance Waiver Explained by:** \_\_\_\_\_  
(Printed Name of Hospital or UPI Representative)

\_\_\_\_\_  
**Signature of Hospital or UPI Representative**

\_\_\_\_\_  
**Date**

