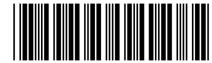
Rady Children's Hospital San Diego


DTF963

Notice & Agreement of Potential Financial Responsibility

Patient Name:_______________	**Guarantor Name:**_______________
Medical Record Number: _______________	

Your provider has recommended that you/your child receive the health care service described below. The service is scheduled for __[date] . Based on information currently available to Rady Children's Hospital-San Diego, it appears that one of the following is true [staff select]:

- ☐ Rady Children's has made the determination that the recommended services are not a covered benefit by your insurance company. Your health plan may consider this service as a non-covered benefit or not medically necessary. The final determination will be the responsibility of your insurance company.
- ☐ The patient is not currently covered under a health insurance plan.
- ☐ Authorization for the recommended service is still pending approval from the health insurance plan - this means the service may be denied and your health insurance plan may refuse to pay for services you receive before the plan issues an authorization.
- ☐ Other _______________

Description of Service/Treatment and associated CPT/Revenue Codes:
____

Estimated Cost of Hospital Service: _______________

Estimated Cost of Physician Services: _______________

What you need to do now:

Review the information below in order to make an informed decision about the care recommended by your Provider. Please feel free to ask any questions regarding the options below.

Select an option below:

☐ **Option 1:** (**YES**). I want to receive/I want my child to receive the recommended health care services. I understand and agree to the following:

1) I agree to pay at the time of service for the above recommended services. I have been informed that my insurance may not cover these services.
2) Insurance (if available), will be billed for the recommended service(s), my insurance company will make a final determination of payment.
   a. **If your insurance issues payment for any portion of these services, a review of your account will be done to determine if a refund is appropriate.**

☐ **Option 2:** **(NO).** I do not want to receive the recommended healthcare services for either myself or my child.

Guarantor/Responsible Party:	**Witness by:**
Print Name: _______________	**Print Name:** _______________
Signature: _______________	**Signature:** _______________
Relationship if not patient:_______________	**Date and Time:** _______________
Date and Time: _______________	

*****My agreement as stated on this form is valid for one year and is applicable to the services listed above*****