

PATIENT LABEL

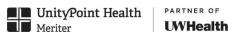


To keep you fully informed of your potential financial	responsibility, we are providing the following noti	fication.
This financial notification is for services rendered at _		(Location)
by	(Provider Name).	
Service/Procedure:	Fee(s) or down payment due at time of servi	ice:
Please check:		
☐ SERVICES THAT MAY NOT BE COVERED BY	INSURANCE	
It is my responsibility to contact my insurance conthat my insurance may not cover the service(s)/provered service/procedure, out of network, denied necessary or other reason indicated by my insurance metwork with UnityPoint Health-Meriter, I am away network with my insurance, (2) UnityPoint Health network, and (3) I know that I will be fully responsible to pay the fee/down payment at or be of service will result in service(s)/procedure(s) in the beapplied to the total charges accrued. My insurance may be applied to the total charges not paid by my insurance may not contact the service may be applied to the total charges not paid by my insurance.	procedure(s) requested due to being a non- ed authorization, denied as not medically ance plan. If my insurance is considered out of are that (1) UnityPoint Health-Meriter is out of th-Meriter has redirected me to a provider in my asible for charges denied as non-covered. I before time of services. Failure to pay at time not being provided. The fee/down payment will trance will be billed, and I agree to be	
□ SELF-PAY		
I have indicated that I do not currently have insufee/down payment at or before the time of service result in the cancellation of my appointment. The charges accrued. I agree to be responsible for p	ces. Failure to pay at the time of service may e fee/down payment will be applied to the total	
☐ COSMETIC  All fees are due at or before the time of service. Feethe cancellation of my appointment. My insurance		
□ DO NOT BILL INSURANCE		
I have requested that my insurance not be billed time of service and will be applied to the total ch		

Page 1 of 2 MR-FORM-1007 101042 Rev. 08/2020

**FOR SERVICES** 

**FINANCIAL NOTIFICATION** 



This financial notification is given in good faith and may visit, including but not limited to, lab/pathology or serv			ıring your
☐ I agree to pay the fees/down payment indicated a accrued.	above and the rem	aining balance of the tota	ıl fees
☐ I authorize the services to be performed.			
☐ I understand that if I am readmitted to hospital for	complications, I a	gree to pay for any fees in	ncurred.
I have read and understood all information presen	ted to me before	signing this consent fo	rm.
			□ am
Patient's Signature	Date	Time	□ pm
Signature of Person Legally Authorized to Consent for Patient	Printed Name of Person Legally Authorized to Consent for Patient		
Consent for Patient	Consent for Pa	uieni	
Reason for Signature of Person Other than Patient	Relationship to Patient		
Signature of Interpreter (if applicable)	Printed Name of Interpreter (if applicable)		
Signature of Witness	Printed Name of Witness		

FINANCIAL NOTIFICATION FOR SERVICES

Page 2 of 2 101042 Rev. 08/2020 PATIENT LABEL