Client Payment Responsibility Agreement

Waukesha County Department of Health and Human Services (Provider)
TAX ID: 39-6005756
TEL: 262-548-7212

Member (Client) Name:		**DOB:**	
Insurance Plan Name:			
Subscriber ID:		**Group Number:**	

By signing below, I agree to pay Provider for those Services determined for the reason(s) specified below:

- Not medically necessary;
- Otherwise not a covered benefit or excluded under my coverage

I understand, pursuant to the Provider's Agreement with _____, that a Provider may not charge me for a service or supply determined not to be Medically Necessary by my insurance plan unless I have specifically agreed in writing, prior to delivery of such services or supplies, to be personally responsible for and pay for such services and supplies. Prior to signing this Client Payment Responsibility Agreement, I understand that my insurance plan determined that the services and supplies listed below were not Medically Necessary/not a covered benefit and excluded under my coverage, and thus not covered by my health plan or insurance. I understand that I may appeal any determination that a service or supply is not Medically Necessary and also authorize the provider to appeal such a determination on my behalf. I further understand nothing in this Agreement may be construed to limit any other rights I have under state or federal law. I also understand that receipt of such services or supplies without my signature below cannot be charged to me personally.

I understand that, for the specified services and supplies listed below received after the date of signature below, I will be personally financially responsible for payment for such services and supplies directly to the Provider and that they are not covered by my health plan or insurance, even though the cost for these services and supplies may not be shown on my Explanation of Benefits ("EOB") as my financial responsibility. I also understand that an appeal of a non-Medical Necessity determination does not assure that I will not be personally financially responsible for services or supplies related to the appeal.

Description of Services and/or Supplies	**Client Responsibility (Cost)**	**Date of Proposed Service**
CPT 90791 Psychiatric diagnostic evaluation/interview without medical service	$299.78	

_____ _____
Signature of Patient or Power of Attorney or Guardian or Legal Representative* Date

_____ _____
Signature of Witness Date

* If signed by a person other than the client, complete the following:

Client is: ☐ Minor ☐ Incompetent ☐ Unable to sign due to disability

Legal Authority: ☐ Parent of Minor ☐ Legal Guardian ☐ Power of Attorney (POA)

☐ Other: _____

* If you check any of the above boxes, you must have proof of legal authority (i.e. Guardianship Papers, Power of Attorney documents) *