ACL Laboratories

We are AdvocateAuroraHealth

Patient Name: _____

Date of Birth: _____

Patient Gender: _____

LABORATORY SERVICES BILLING WAIVER: FINANCIAL RESPONSIBILITY AGREEMENT

(not for use with Medicare Part A or B)

Only used for ACL Outreach Client Office

Notice Date: _____

Service(s): _____

I understand the non-emergency service(s) identified above may not be covered (paid) by my health plan for one or more of the reason(s) listed below:

- ACL Lab may be out of network for my insurance plan, does not participate in the plan, or is not part of the network choice that pays the highest benefits for me. My service(s) may be paid at a reduced rate or, may be denied as non-covered, or I may need to submit a claim to my plan. Using ACL Lab for my services means I will owe a larger patient portion, and I may owe the full charges.
- My insurance authorization or HMO referral has not been approved.
- I have exceeded my allowable frequency of services/visits based on information provided to me by my insurance provider.
- My health plan has made the determination that my planned service(s) will not be covered.
- My insurance plan deems the medically necessary services as investigational/experimental/unproven and I understand they will not be covered.
- Other (specify) _____

I understand that by proceeding with these services, I am accepting full financial responsibility. This waiver will override the patient responsibility statement on the explanation of benefits from my insurance plan.

_____ _____ _____

Date Time Patient/Guarantor signature (if patient is a minor or otherwise not financially responsible)

ACL Outreach Client Location: _____

_____

ACL Account Name: _____ ACL Account Number: _____

For any questions call the ACL Revenue Cycle: **1-800-877-7016 Option 1**

Interpreter Assistance: If an interpreter assisted, please complete the following: Language: _____

Date: _____ Time: _____ Interpreter Name: _____ ID #:_____