



Affix Patient Label

Patient Name:

Date of Birth:

**Advance Financial Responsibility Notice (AFRN)  
Non-Participating Insurance Plans and/or Non-Covered Services**

<b>Patient Name:</b>	<b>MRN:</b>
<b>Insurance Carrier:</b>	
<b>Date of Service:</b>	
<b>Type of Service</b> (including CPT/HCPCS codes):	
<b>Estimated Cost for Today's Services:</b>	

**By signing below, I acknowledge that:**

- A referral from my Primary Care Physician (PCP) is required for any non-emergency outpatient hospital or specialist services. I acknowledge that I do not have a referral on file, but I choose to receive services without the required referral. I understand that without the appropriate referral I may be held responsible for some or all payments incurred for these services.
- I understand that this procedure or test may not be covered by my insurance carrier and I agree to be financially liable for any payments not covered by my insurance.
- I understand that I will be responsible for all fees incurred for this visit or any other services as my insurance coverage is not in effect on this date.
- I am a Medicaid beneficiary and have chosen to *waive my benefits for today's services. I understand that my Medicaid plan will not be billed.* I am choosing this option as the provider is non-participating with my Medicaid plan or the requested service is a non-covered Medicaid service. Medicaid does not pay for experimental or research services. **I agree to pay the entire amount due today.**

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter's Statement:

I have interpreted this consent form to the patient, a parent, closest relative or legal guardian.

Voice/Video Service: \_\_\_\_\_ Interpreter ID #: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_

Interpreter Name (printed): \_\_\_\_\_ Agency: \_\_\_\_\_

Interpreter Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_