BRONSON	Affix Patient Label
	Patient Name: DOB:

Notice of Financial Responsibility for

Non-Participating Medicaid Plans and Non-Covered Medicaid Services

Patient Name:	**MRN:**
Medicaid Plan:	
Date of Service:	**Type of Service** (*including CPT/HPCS codes)*:
Estimated Cost for Today's Services: $_____.____	

By signing below, I acknowledge that:

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 either not covered or not authorized by Medicaid. ***I agree to pay the entire amount due today***.

Signature of Responsible Party Date

Signature of Witness Date