Cayuga Medical Associates

NON-PARTICIPATING/SELF PAY NON-EMERGENT SERVICES/SURPRISE BILL WAIVER

Patient: Account #:

Provider:

Location:

Insurance: Policy #:

Non-Participating/Self Pay Waiver:

I have been verbally informed on (month/date/year) by Cayuga Medical Associates, PC that they do not participate with my insurance and my medical claims will be processed as "Out of Network"/uninsured.

If applicable, as a courtesy, CMA will submit the claims to your insurance carrier for processing. Since there is no participating agreement with your plan, you will be responsible for the full payment of these charges. The amount received from your plan is NOT acceptable as payment in full. For any questions regarding reimbursement, please contact your insurance carrier directly.

The ESTIMATED charges for services are available upon request.

The undersigned accepts full responsibility for all items or services provided, and have agreed to complete the appointment on Month/Day/Year.

Patient Signature