INTEGRIS HEALTH

Health Insurance Relinquishment Form
Payment Responsibility for Elective Private Pay Procedure Form

Purpose: To provide a legal document where the patient signs preventing them to file their insurance **and** utilize our private pay discount.

- More employers are putting more of the health care costs back on the employees by increasing their deductibles, etc. We are finding more patients who are choosing to be a private pay patient vs. filing the claim with their insurance company and it going against their deductible. They seem to not realize that they will eventually have to pay that deductible someday.
- In the past, we have had instances where the patient claims to be self-pay and then files the claim to their insurance company at a later date. Insurance pays and then patient wants a refund if the insurance paid more and the patient responsibility was not as high as the patient originally anticipated. Basically, the patient is trying to find the cheapest route…. filing insurance or utilizing our private pay 45% discount policy. The number of these instances seem to be growing as patients are "price shopping" more.
- Attached is the Health Relinquishment Form that has been approved by INTEGRIS Health legal counsel. If the patient chooses to become self-pay instead of filing insurance, the patient will sign the attached form as well as signing the appropriate Payment Responsibility for Elective Private Pay Procedure Form.

Patient Label
Patient Name:
MRN:
DOB:

INTEGRIS HEALTH

HEALTH INSURANCE RELINQUISHMENT FORM

Name of Patient: _____

Date of Procedure: _____

THIS IS A LEGAL DOCUMENT. READ IT CAREFULLY BEFORE SIGNING AND MAKE SURE ALL THE BLANKS ARE COMPLETED. YOU WILL BE LEGALLY BOUND BY THIS DOCUMENT.

INTEGRIS Health Hospitals, Clinics, Ambulatory Surgery Centers, or facilities hereinafter referred to as "the Entity".

The above referenced patient is scheduled for (procedure) _____ at INTEGRIS Health _____ (the "Entity") on or about the date referenced above. I, _____, the patient, voluntarily wish to relinquish my right to file this claim to my health insurance company. I choose to be a private pay patient and acknowledge and understand that I am fully responsible for all charges associated with this Entity's procedure. I acknowledge and understand that this represents the Entity charges only and does not include any physician or other professional charges, including, but not limited to radiologists, anesthesiologists, pathologists, etc., for which I will be separately billed.

I, the patient, agree to not file a claim to my health insurance company at a later date. If, for some reason, I do file a claim with my health insurance company and, regardless of their payment amount, I acknowledge and understand that I will not receive any type of refund from the Entity for this particular Entity's procedure.

Patient acknowledges that Patient's Physician is required by law to obtain patient's consent to perform the procedure listed above and to inform patient of the risks, benefits, and alternatives to the procedure. Patient is aware that the practice of medicine and surgery is not an exact science and acknowledges that no guarantees or warranties have been made concerning the results of this admission or any procedures performed by Patient's Physician. Patient understands that Patient's Physician, his/her associates, or assistants, shall be responsible for the performance of his/her own acts related to this admission and any procedures they perform. The Entity is not liable for the acts or omissions of Patient's Physician, his/her associates, or assistants.

THIS IS TO CERTIFY THAT I, THE UNDERSIGNED, BEING THE PATIENT, OR ANOTHER PERSON LEGALLY AUTHORIZED TO ACT FOR THE PATIENT, HAS READ THE ABOVE, UNDERSTANDS ITS CONTENTS, ACCEPTS ITS TERMS, AND HAS RECEIVED A COPY.

_____ _____

Signature Date/Time

_____ _____

Signature of Guarantor (if applicable) Witness to Signature

IF PATIENT IS UNABLE TO SIGN:

_____ _____

Signature of Person Legally Authorized to Act for Patient Date/Time

Patient Label
Patient Name:
MRN:
DOB: