150 S. Andrews Ave (Ext)
Suite #201
Pompano Beach, FL 33069

www.BrowardOutpatientUrgentCare.com
Phone: 1.888.646.2273
Fax: 1.888.745.7020

INSURANCE WAIVER

Patient Name: ____________________________________ File: _________________

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realized my care may be subject to pre-authorization by my insurance company, and I accept any responsibly for charges which may not be approved. My Insurance company will review any/all documents submitted by **BROWARD OUTPATIENT URGENT CARE** for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, co-insurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied and this may be beyond the offices ability to notify me prior to render acute/emergency care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

I understand this office will require payment for me for any services not covered by my health plan.

Assignments of Benefits:
I hereby authorized my insurance benefits to be paid to ____
I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

____
Signature (Patient, or Parent/Guardian of Parent)