Insurance Waiver Form

Reproductive Care of Indiana
Michael A. Henry, M.D.

Please read through this waiver form, find the section that applies to you and if applicable, and sign and date.

*****If you have insurance and RCI is in your network,***
please disregard this form and fill out the Insurance Verification Form**

SELF-PAY PATIENTS WITHOUT INSURANCE

***If you do not have insurance, you are a self-pay patient. Please sign the waiver below.*

I acknowledge that I **DO NOT** have insurance and have elected to be seen as a **SELF-PAY PATIENT**. I am agreeing to assume **ALL** financial responsibility. This agreement pertains to todays and all future visits.

Signature Date

PATIENTS REQUIRING REFERRALS

***If your insurance company requires you obtain a referral in order to see a specialist, your Primary Care Physician MUST authorize visits to the specialist BEFORE the visit occurs. If you were unable to obtain such referral, please sign the waiver below.*

I acknowledge that I have not obtained an authorized referral from my Primary Care Physician. I am agreeing to assume ALL financial responsibility. This agreement pertains to todays and all future visits without an authorized referral.

Insurance Company PCP

Signature
Date

OUT OF NETWORK INSURANCE COVERAGE

***If your insurance does not include Reproductive Care of Indiana in their network, they may not cover services rendered. If this situation applies to you, please sign waiver below.*

I acknowledge that I have been informed that my insurance carrier is **OUT OF NETWORK** therefore, is not accepted. I am agreeing to assume ALL financial responsibility. This agreement pertains to todays and all future visits with this insurance carrier.

Insurance Company

Signature Date

PROOF OF INSURANCE

***If you have insurance coverage and do not have your insurance card at your appointment or if you are waiting on insurance coverage to begin and do not have proof of said insurance, please sign the waiver below.*

I acknowledge that I DO have insurance but have NOT presented an insurance card and will be processed as a **SELF-PAY** patient unless a front and back copy of my insurance card is presented to the office within 30 days of the date of service.

Insurance Company

Signature Date