Mariposa
speech services
3145 E. Chandler Blvd 110-117, Phoenix, Arizona 85048 | Phone 602.828.2619 |

Financial Responsibility Acceptance Form

Patient Name: _____ Services Rendered: _____
Insurance: _____ ID: _____

This form is to inform the patient and responsible party that, if your insurance denies claims/refuses to pay for services rendered by Mariposa Speech Services due to the services:

- Not being medically necessary under your insurance plan, and/or
- Investigational under your medical policy guidelines

The patient/responsible party will be financially responsible for the full amount billed to insurance for services rendered.

The fact that your insurance may not pay for a particular service does not mean that you should not receive it. Please feel free to ask any questions or express concerns that you may have on this subject. The purpose of this form is to help you make an informed choice about whether you want to receive these services knowing that you might have to pay for them yourself.

Please choose one option. Sign and date.

____**Yes**, I want to receive these items or services. I understand that:

- My insurance will not decide whether to pay unless I receive these services and my provider submits a claim to my insurance
- My insurance will decide whether to pay based on the claim that my provider submits, any supporting medical records, the terms of my benefit plan, and my insurance's medical policy guidelines.
- If my insurance denies the claim as not medically necessary or investigational, I will have to pay for the full amount of these services myself, and I agree to be personally and fully responsible for payment.
- If my insurance does pay the claim, Mariposa Speech Services will refund to me any advance payments I made to Mariposa that are due to me.
- I can appeal my insurance's decision.

____ **No,** I have decided that I do not wish to pay for these services if they are either not medically necessary or are investigational. I understand that Mariposa Speech Services may choose not to provide these services because I have not agreed to pay.

Signature of patient or person acting on patient's behalf Date

Printed name of patient or person acting on patient's behalf Date