EVALUATION INSURANCE WAIVER
FOR PSYCHOLOGICAL EVALUATIONS

Patient's Name: _____
Identification Number: _____
Provider Name: _____
Provider Number: _____

Provider Address: Central Kansas Mental Health Center
809 Elmhurst
Salina, Kansas 67401

The provider must document in the patient record the discussion with the patient regarding the following service(s).

NOTICE OF PERSONAL FINANCIAL OBLIGATION
Read Before Signing

I have been informed and do understand that the charge(s) for _____
(nomenclature/procedure code/appliance)

Provided to me from:_____ thru _____(dates) may not be covered because your insurance company may consider this service(s) to be:

- ☒ Not medically necessary, non-covered diagnosis
- ☒ Non-Covered or Non-Contracting Provider
- ☒ Court Ordered, Insurance does not provide benefits
- ☒ Non-covered service

It is my wish to have this service(s) performed even though it may not be fully paid by my insurance company.

I UNDERSTAND THAT I WILL BE HELD PERSONALLY RESPONSIBLE FOR APPROXIMATELY $ _____. This amount is an approximation only, based on the service(s) scheduled to be provided.

Acknowledgement of personal financial obligation applies to charge(s) for service(s) specified above when performed by this or another provider(s).

I further understand any additional service(s) could affect the amount of my financial responsibility.

_____ _____
Patient Date

_____ _____
Parent / Guardian / Payee Signature Date

I, _____ (witness name), did personally observe and do certify the person who signed above did read this notice and did affix his/her signature in my presence.

_____ _____
Witness Signature Date