AGREEMENT OF FINANAICAL RESPONSIBILITY

The purpose of this form is to help Tri-Care/Tri-West/UHA members make an informed choice about whether or not they want to receive the services, items or services listed below, knowing that they might have to pay for the services themselves. Members must be given ample opportunity to review this form and discuss it, as well as service options with his/her provider.

Notice from Provider (Speech Pathology of Hawaii) **to Member** (you)

Insurance will only pay for services that meet their payment determination criteria as set forth in your health plan. If your insurance carrier determines that a particular service or day of service does not meet their payment determination criteria, your insurance will not pay for that service. I believe that, in your case, your insurance probably will not pay for these reasons to include but not limited to the following:

Service	*Initials*	*Estimated Charges*
A particular day(s) of service that does not meet their payment criteria		*Please refer to the explanation of fees to determine estimated charges*
A particular day(s) of service that isn't paid in full by you insurance carrier		
Transportation Fees		
Consultation Fees		
Paperwork Fees		
Materials Fees		
Cancellation Fees and Policies		
Screening Fees		
Group Services		
Bad Check Fees		

Speech Pathology of Hawaii
DBA Speech Solutions

Effective November 8, 2012

Beneficiary Agreement
This agreement is between me (the insurance beneficiary whose signature appears below) and my provider, whose name is Speech Pathology of Hawaii (DBA Speech Solutions);LLC. I have been notified by my provider that he or she believes that, in my case, my insurance will probably not pay for the services or items identified above. If your insurance denies payment, I agree to be personally and fully responsible for payment of the services, items, or laboratory tests for which the provider's estimated charge is show on the explanation of fees. I understand that the charge above is only an estimated charge and may not be the actual charge or total amount I will be responsible for:

Beneficiary: Please write your initials in the boxes above for those services in which you agreeing to pay the provider

I understand that for each service listed above, my insurance may not pay for the service because the service may not meet their payment determination criteria. By signing below, I request that each service which I have initialed in the boxes above be rendered. If my insurance carrier denies payment for the service, I agree to pay my provider in full for each service.

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Printed name of beneficiary or authorized representative

____ ______________
Signature of beneficiary or authorized representative Date