Keck Medical Center of USC

Patient Advance Notice of Charges for Medical Services

_____("USC Provider") is accepting the patient named herein as a cash paying patient based upon the statement made by the patient below for the services described below.

Patient Name (print): _____ **DOB** _____
Medical Services:

_____
(Summary of Services including Date of Service)

I,_____("Patient") am presenting myself as a cash-paying patient. As such, I personally assume all financial responsibility and obligation to pay in full the billed charges of the services and materials provided to me by the USC Provider upon my receipt of them. If I have any type of insurance coverage, I understand that these above services are either (1) considered out of network benefits; (2) not covered benefits; or (3) covered benefits that my insurer has to date not authorized me to receive.

I understand that the USC Provider may not be a contracted provider with my health insurance company. I understand that the USC Provider has no control over the insurance company's determination of the normal usual and customary charge or how the insurance company determines allowable charges. In the event my insurance company pays some portion of the medical services, I agree to pay the difference in full *regardless* of the amount that my insurance company may determine to be the "usual and customary" charge.

If the USC Provider is a contracted provider with my insurance company, but the services have not been authorized, or are not covered benefits, I understand that the rates that the USC Provider charges the Patient will in many cases be higher than the discounted contract rate the USC Provider has agreed to accept from the insurance company when services are authorized and/or covered. I expressly agree to pay the USC Provider's higher, billed charges amount.

I understand that the USC Provider is agreeing to provide the agreed-upon medical services on the terms stated above. I waive all rights that I or my insurer may have to pay the USC Provider at contractually discounted rates, which might have been applicable had my insurer authorized the services before they were performed and/or had the services been a covered benefit. I acknowledge that, if my insurer authorizes these services after they have been performed and reimburses me at rates less than the USC Provider's full billed charges, the USC Provider will have no obligation to reduce its charges or to return any part of my payment to me.

☐ I do not want my health information to be sent to my health plan.

_____ _____
Patient Signature **Date**

_____ _____
USC Provider Representative **Date**

Note: This form should <u>not</u> be used for any patient whose health care is covered by a governmental agency.