Main Line Health® | BEHAVIORAL HEALTH

Patient Notification of Financial Responsibility

_____ _____

Patient Name Date of Birth

I understand that my Physician/Medical Provider is recommending an outpatient behavioral health service(s) below that may not be reimbursed by my health insurance plan. By signing this form, I agree that I wish to have this service performed and that I have been notified, in advance, that Main Line Affiliates believes that this service(s) may not be paid by my health insurance plan for the reason indicated below.

I agree to be financially responsible for this service.

_____	Outpatient Mental Health Therapy Session	_____
Date	Service	Patient Signature
_____	Outpatient Mental Health Therapy Session	_____
Date	Service	Patient Signature

I understand that the reason that Main Line Affiliates believes that my insurance is likely to deny payment is checked below:

_X_ My insurance may not or does not cover this service for the diagnosis indicated.

____ Other _____

We want to thank you for choosing the Women's Emotional Wellness Center. It is our goal to provide you and your family with the highest quality of care.

Note: Insurance plans often have coverage limitations for certain medical services based on the terms of the benefit plans they have established. Some insurance plans deny services as "not reasonable or necessary." Other insurance plans may reject medical services due to eligibility, location and service frequency exclusions. Main Line Affiliates encourages you to discuss such issues and questions with your insurance representative who makes the final decision on whether this service will be paid or denied.