HOUSTON Methodist SM
ORTHOPEDICS & SPORTS MEDICINE

Patient's Name: _____ Date of Service: _____

Provider: _____

Notice of Financial Obligation

In the event that your insurance will not pay for the item(s) or service(s) that are described below we are required to alert you of your financial obligation. The fact that your insurance may not pay for this service does not mean that you should not receive it. There may be a good reason why your doctor recommended it. But we want you to understand your financial obligation should your insurance not pay for this service. The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself.

The service in question:

(Estimated Cost: $450 per injection). Please note that this is just an estimate. Costs are subject to change at any time. Houston Methodist Orthopedics & Sports Medicine will work efficiently to inform patients of changes in costs prior to providing services. Financial arrangements must be made prior to obtaining services.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.** I understand that my insurance may/may not cover these items and/or it may apply towards one of my deductibles. It is my responsibility to contact my insurance company for detailed explanations. I understand that I am financially responsible for all fees which are not covered by my insurance company. Payment arrangements must be made prior to services rendered.

☑ **Option 2. NO. I have decided not to receive these items or services.** I will not receive these items or services at this time and was made aware of alternate choices by my rendering physician.

_____ _____

Signature of Patient or Responsible Party **Date**