

Sample Waiver of Liability Form

I, _____, acknowledge that the service listed below may not be covered by my insurance plan because of a medical necessity determination. My physician, Dr. _____, feels the service is medically necessary to maintain urine flow and allow voluntary urination. I agree to follow his/her medical care regimen, which includes acceptance of insertion of The Spanner prostatic stent.

The medical necessity of this service has been fully explained to me, and I understand the extent of the clinical situation.

In the event this treatment is not covered by my insurance plan, I agree to pay, in full, for the service listed below. If I cannot pay this amount in full, I agree to make payment arrangements with the doctor's billing office staff.

Service: 0084T Insertion Temporary Prostatic Urethral Stent
Estimated Cost: \$
Check appropriate box: I will pay for the service
 I have decided not to receive this service

I have read, signed and dated this form prior to the service listed below being rendered to me.

Patient Signature

Date

To be retained in the patient's medical record, also provide the patient with a copy.