



Insurance Verification & Financial Responsibility Waiver

Patent Name: _____ DOB: _____

Date of Visit: _____

1. Notice of Unverified Insurance

We have attempted to verify your insurance coverage through our systems. At this time, your coverage status is **Unverified** or **Inactive**. This may be due to a technical error, a change in your policy, or an issue with the insurance carrier.

2. Your Options (Choose One)

- **Proceed with Visit:** I choose to receive services today. I understand that I am responsible for the costs if my insurance does not cover the visit.
- **Reschedule:** I prefer to reschedule my appointment for a later date once my insurance coverage is confirmed.

3. Good Faith Estimate (GFE)

Because your insurance is currently unverified, we are treating this visit as "Self-Pay" for today. Under the **No Surprises Act**, you have the right to an estimate of what today's visit will cost:

- **Estimated Base Office Visit:** \$ _____
- **Estimated Labs/Tests (if applicable):** \$ _____
- **Total Estimated Responsibility:** \$ _____

> *Note: This is an estimate. Final charges depend on the actual care provided.*

4. Patient Acknowledgment

By signing below, I agree that:

- I am choosing to receive **non-emergency** care today.
- If my insurance carrier denies the claim or determines I am ineligible, I accept full responsibility for the charges listed in the estimate above.
- If my insurance is later verified as **Active and In-Network** for today's date, the practice will bill my insurance and refund any overpayment I made, per Connecticut law.

Patient/Guarantor Signature: _____

Staff Witness: _____