Texas Children's Hospital®

TEXAS CHILDREN'S HOSPITAL CLIENT ACKNOWLEDGEMENT STATEMENT – "CAS"
INCLUDES: NON-COVERED, NOT AUTHORIZED, OUT OF NETWORK & SELF PAY SERVICES
(For Medicare patients please reference ABN form)

PATIENT INFORMATION				
Patient Name:			**HAR:**	
			CSN:	
Date of Birth:		**Home Phone Number:**		
Gender:		**Cell Phone Number:**		
Home Address:			**Email Address:**	

REQUESTED SERVICES			
Description of Services	Travel Medicine Services (consultation, vaccinations, etc)		
Date of Service:		**Location of Service:**	Texas Children's Hospital

The above referenced services and associated service have been determined to be:	
☐	Non-covered (*e.g. excluded benefits, pre-existing)*
☐	Not Authorized Services
☐	Out of Network *(e.g. provider is out of network, reduced coverage, higher patient liability*
■	Self-Pay *(includes true self pay and out of network plans not accepted by the provider(s))*
☐	Patient or guarantor has coverage, but elects to pay for services out-of-pocket
☐	Other:

I certify that my relation to the patient is:					
☐	Father	☐	Self	☐	Managing Conservator
☐	Mother	☐	Legal Guardian	☐	Other:

I am financially responsible for all hospital and professional fees related to this visit ***(initial)*** ☐

The above services: (1) are considered non-covered or not authorized by Medicaid or the insurance carrier; or (2) are out of network; or (3) there are no confirmed financial resources at this time (self-pay); or (4) guarantor has insurance and elects to pay for services out of pocket. Therefore, I understand that ***I WILL BE RESPONSIBLE FOR PAYING FOR THE ABOVE-DESCRIBED SERVICES.*** I am aware that the provider(s) may not file a claim to Medicaid or insurance for services provided to the above-mentioned patient. This acknowledgement covers Hospital charges and/or professional fees where necessary. Professional fees may include, but are not limited to, radiologists, anesthesiologists, pathologists attending/admitting and consulting physicians.

Signature	***Print Name***
Witness Signature	***Print Name***

(Please scan into EPIC Documents Table)