MEMBER/PATIENT RESPONSIBILITY AGREEMENT
Dr. Ajakwe and Dr. Tatevossian

Participating health care professionals/facilities ("Providers") are prohibited from charging members for any service, product or upgrade (collectively, "Service") that is deemed not medically necessary, unless the member specifically requests such Service and agrees in writing to be financially responsible for It. This waiver form shall be used to document the Member s agreement to be responsible for such Services, To be effective and valid, this document must be executed prior to the delivery of any non-medically necessary Service.

Member/Patient Name :(Please Print) _____

DOB:_____ Insurance Carrier: _____

Policy #:_____ Date Of Service:_____

Provider: **BUENA VISTA ANESTHESIA MEDICAL GROUP**
Provider Phone: **(818) 331-1036**
Provider Tax Id: **95-4444226**

By signing below, I agree to pay Provider for those Services determined for the reason(s) specified below not to be covered under my Benefit Agreement:

- ❑ Not medically necessary;
- ❑ Primarily for comfort and convenience; or
- ❑ Otherwise not a covered benefit or excluded under my coverage

I understand that a Provider may not charge me for a Service determined to be not medically necessary unless I specifically agree to pay for it. I also understand that the Provider and/or I may appeal any determination that a Service is not medically necessary by filing a grievance or appeal with my Health Plan or the Department of Managed Health Care ("DMHC") pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may also have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC.

For the Services listed below, I also understand that I am responsible for the difference between the covered expenses for any covered services and the Total Cost listed below, even though they may not be shown on my Explanation of Benefits (EOB) as my responsibility. If the Total Cost of the Service is not a covered expense under the applicable Benefit Agreement, I understand that I am responsible for the Total Cost.

Date of Service	Service or Product	Patient Responsibility
		$
		$
		$
		$

_____

Member/Patient Signature Date