Westside Medical Associates of
Los Angeles
99 N. La Cienega Bl. Suite 103
Beverly Hills, CA. 90211

ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY FORM

MEMBER ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

PROVIDER This form must be used for ---------- members who wish to receive Healthcare services from you that may not be covered by their_____ plan.

MEMBER Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- the services are not covered under your _____ Plan, or,
- the services have not been otherwise approved for payments by_____

SERVICES (Any service not described as a covered benefit in the member's Evidence of coverage)

_____
_____
_____

Member or Member's Legal
Representative Name (Please Print) ----------

Member or Member's Legal
Representative Signature ---------- Date: ----------

PROVIDER : ----------

**Provider orProvider
Representative Name** ----------

**Provider or Provider
Representative Signature** ---------- **Date:** ----------