



\* M R Q 2 9 1 \*

PATIENT/GUARDIAN ACKNOWLEDGEMENT FORM

USE LABEL OR PRINT

NAME

BCH MRN

DOB

### ASAP Fee Schedule Acknowledgement Form

I have received the following information:

1. \_\_\_ Orientation information regarding the Adolescent Substance Abuse Program (ASAP) at Boston Children's Hospital, including available services.
2. \_\_\_ Fee schedule for services provided.

**I acknowledge that if any of the above referenced items or services is not considered medically necessary by my insurance company or is a non-covered service, I am financially responsible for the full amount should the claim be denied. If I am denied insurance coverage for any service, discounts may be available.**

### Patient Representative/Patient Signature

\_\_\_\_\_  
Name of Patient Representative (printed):

\_\_\_\_\_  
Patient Representative's Signature

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

The patient should sign if over 18 or emancipated. Patient Representative and patient should both sign if child is under 18 but old enough to understand.