Boston Children's Hospital

USE LABEL OR PRINT
NAME

BCH MRN

DOB

PATIENT/GUARDIAN ACKNOWLEDGEMENT FORM

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.