SPECTRUM BEHAVIORAL HEALTH

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Suite F
Arnold, MD 21012
Office: (410) 757-2077

49 Old Solomon's Island Road
Suite 303
Annapolis, MD 21401
Office: (410) 573-1944

VOLUNTARY WAIVER OF INSURANCE BENEFITS

Signing this document will alter your legal rights under Maryland law. Please read carefully and do not sign unless you understand the document.

I, _____, am seeking mental health professional services from
(Patient, Parent, or Guardian)

Spectrum Behavioral Health (also known as Arundel Mental Health Professionals, L.C.).
The patient (either my dependant or myself) is an active member of a health insurance plan. I have been informed that:

☐ The provider who will render services to me, or my covered dependent, does not participate or contract with my insurance carrier/plan.
OR
☐ The service I am requesting is not a covered benefit/service under the terms of the insurance plan.

I understand that I, instead of my insurance plan, will be financially responsible for professional service fees associated with services rendered and I agree to pay charges in full at the time of service.

I understand that if I had elected to obtain treatment from a healthcare provider who participated with my insurance plan and it was determined that the services were covered under my benefit plan, I would have been entitled to have this service reimbursed as set forth in that plan;

Therefore, this means that

- I am solely responsible for my provider's charges
- My provider will NOT submit claims to nor seek payment from my insurance plan for these services;
- I will be solely responsible for notifying my provider of authorization processes required by my plan.

Patient Name: _____ D.O.B: _____

Insurance Carrier: _____ Phone # _____

Subscriber Name: _____ Insurance ID # _____

Signature: _____ Date: _____
(Patient/Guarantor)

Witness: _____ Date: _____
(SBH Employee)