WAYPOINT
ORTHOPAEDIC ASSOCIATES

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INSURANCE WAIVER - AUTHORIZATION DENIAL

Date: _____

Patient Name: _____

Health Insurance Carrier: _____

I _____, hereby declare and affirm the following statements:

Desire to Use Health Insurance: I had the intention and preference to use my health insurance for covering the costs associated with the medically recommended procedure.

Denial of Authorization by Insurance Company: My health insurance company has denied authorization for the recommended surgery. This decision was made despite my healthcare provider's recommendation and my willingness to undergo the procedure.

Non-recognition of Prior Conservative Care: Prior to receiving the recommendation for surgery, I engaged in conservative care treatments as advised by my healthcare provider. However, my health insurance company did not recognize these efforts as sufficient or valid towards the necessity for the recommended procedure.

Insurance Company's Stance on Additional Conservative Treatment: The insistence by my health insurance company on additional conservative treatment is not in line with the medical advice I have received. This stance requires me to continue living with unwanted pain and discomfort, which negatively impacts my quality of life.

Impact of Denial on Health and Well-being: The denial of immediate authorization for surgery by my health insurance company has left me in a state of continued physical pain and emotional distress. This situation has further complicated my health condition and prolonged my suffering.

Understanding of Financial Implications: I fully understand that by choosing not to utilize my health insurance, I will be personally responsible for all costs associated with the procedure. I acknowledge that these costs may be significantly higher than those typically covered by insurance.

I affirm that the information provided in this affidavit is true and correct to the best of my knowledge and belief.

Signature: _____

Print Name: _____

Date: _____