

Informed Consent

Agreement to Pay Fee-for-Service Clients

*This form must be completed in full before providing a
Service or item to a DSHS/Medical Assistance Client*

Client name: _____ ID/PIC# _____

- I understand that the specific services listed below **are not** covered by my DSHS/Medical Assistance program and are not included as part of another service, or have been determined by DSHS to not be medically necessary.
- I choose to receive the specific service(s).
- I agree to pay for the specific service(s).

SPECIFIC SERVICE(S) CLIENT AGREES TO RECEIVE AND PAY FOR:

This agreement is void and unenforceable, and I am under no obligation to pay the provider, if my DSHS medical program covers the services listed above or if the provider fails to satisfy DSHS conditions of payment as described under WAC 388-87-010(6).

I understand the purpose of this form and all my questions were answered to my satisfaction.

Signature of Client/Parent/Guardian/Representative

Date

Signature of Provider

Date

Note to Providers: The services or items listed above must be specific in nature. Document steps taken to assure that the client fully understands the purpose of this form and that the form has been interpreted and/or translated as necessary. For Healthy Options Managed Care clients, see WAC 388-538-095(5)