Oklahoma State University
Center For Health Sciences
1111 South 17th St.
Tulsa, OK 74107
918-582-1972

Do Not File Insurance Waiver Form

I _____ do have valid insurance on this date: _____.
(Patient Name) (Today's Date)

I do not wish for Oklahoma State University Medicine to file a claim with

_____ Insurance Company for _____ Date of Service
(Insurance Company Name) (Date of Service)

with Doctor _____. I acknowledge this waiver of right to file insurance is only
(Doctor Name)

valid for this one date of service. I acknowledge that if I wish to have another date of service not be filed with my insurance that I will submit another request of waiver. I accept that I am personally responsible for the payment of the services rendered and not the aforementioned insurance company.

_____ _____
Patient Signature Date

This form must be filled out in its entirety to be effective, any failure to fill out the form on the part of the patient, does not constitute a binding agreement between OSU and the patient. This request will only be honored if no other laws or regulations supersede this request. Oklahoma law requires that we advise you that the* ***information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information. If the patient is diagnosed or is treated for any of the above, but not limited to the above, this waiver is subject to being void.

OSU does not claim that any other provider or provider agent outside of OSU will honor this request, nor can OSU expect any other provider to do so. The patient is expected to ask the same request of other non-OSU providers if they expect to not have their claims submitted for similar reasons.