Bates PHARMACY & MEDICAL SUPPLY

INFORMED CONSENT

Agreement to Pay

(for a fee-for-service client)

This form must be completed in full before providing
a non-covered service or item to a DSHS medical assistance client.

CLIENT NAME: _____

- 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. Furthermore, these services are not covered under my Medicare Prescription Drug Program.

- 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: **Qty** **Price**

Note to Providers : *The services or item 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.

_____ _____

SIGNATURE OF CLIENT/PARENT GUARDIAN/REPRESENTATIVE DATE

_____ _____

Bates Pharmaceutical Services DATE
3704 N. Nevada
Spokane, Washington 99207
509-489-4500 ext 604