CLINICAL LABS
OF HAWAII
PAN PACIFIC PATHOLOGISTS, LLC

AGREEMENT OF FINANCIAL RESPONSIBILITY

Your healthcare insurance provider ("Insurance") will only pay for services that meet the payment determination criteria as defined by the policies and procedures of your health plan and the benefits described therein. If your Insurance determines that a particular service does not meet its payment determination criteria, it will not pay for that service and you will be financially responsible for payment.

The purpose of this form is to help you make an informed choice about whether or not you want to receive the services, items or laboratory tests listed below because we believe that in your case, your Insurance may not pay for the service(s) listed below. Please take the opportunity to review this form and, if necessary, discuss it with your physician.

Please initial the boxes to the left of each service which you would like to receive and for which you agree to pay, if Insurance denies payment for any reason.

Initial	Service	Esitmated Charge
*	SARS-CoV-2 RNA by TMA	$150.00

Beneficiary Agreement

This agreement is between me and Clinical Laboratories of Hawaii, LLP/Pan Pacific Pathologists, LLC (collectively "CLH"). I have been notified by CLH that my Insurance may not pay for the services, items, or laboratory tests identified above. If my Insurance denies payment, I agree to be personally and fully responsible for payment of the services, items, or laboratory tests for which the provider's estimated charge is shown above. I understand that the charge above is only an estimated charge and may not be the actual charge or total amount for which I may be responsible.

I understand that for each service listed above, my Insurance may not pay for the service because the service may not meet its payment determination criteria. By signing below, I request that each service that I have initialed in the boxes above be rendered. If my insurance denies payment for the service, I agree to pay CLH in full for each service.

Printed Name of Beneficiary or Authorized Representative

Insurer's Name

Subscriber No. (e.g. HMSA XLPR000009999999)

Signature of Beneficiary or Authorized Representative

Date Time