



PATIENT-PAID HEALTHCARE HOSPITAL INFORMATION

TO BE COMPLETED BY PATIENT

Name	DOC Number
Service(s) requested	

The named patient is incarcerated at _____ and is requesting you provide the service(s) listed above. Facility Name

The Department of Corrections is **not** paying for these services. The patient will deposit funds sufficient to cover your estimated cost plus a small additional amount to cover unanticipated costs in a trust account. You will be paid from this trust account. Please provide the requested information, copy this form, and mail the original directly to:

Name: _____ Address: _____
Phone: _____ City: _____ Zip: _____

TO RECEIVE PAYMENT: Complete service(s), attach a copy of this form to your final invoice, and mail to the facility's Business Office at the above address.

TO BE COMPLETED BY HOSPITAL ADMINISTRATOR

Hospital Name	
Address	
Contact Person	Phone Number
Diagnosis	
Surgery/Procedure to be Performed	

PRESCRIPTION MEDICATIONS

If you anticipate the need for prescriptions, please attach them to this form before mailing. Non DOC formulary medications require approval. If the medication is not approved, you will be contacted. When the procedure is complete, prescriptions will be filled in a community pharmacy and administered to the patient according to established DOC protocols for medication administration. Sample medications or dispensed medications are not permitted and will be destroyed.

HEALTH SERVICE	ESTIMATED COST
Room and board	
Surgery and recovery room	
Anesthesia services	
Anesthesiologist fees	
Other ancillary services (list):	
Other professional fees (list):	
TOTAL	

WAIVER STATEMENT

The Department of Corrections shall not incur any costs related to the receipt of care, including the real or potential complications, which may result. The patient is financially responsible for this care and related expenses. The Department of Corrections will not accept liability or expense of any kind as a result of the treatment provided. If approved, your office will be contacted by the Health Services Manager/designee to make final arrangements and answer questions. By my signature, below, I acknowledge that I have read and understand the waiver statement.

Practitioner's Signature

Phone

Date

State law and/or federal regulations prohibit disclosure of this information without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.