

Medical Associates of Yakima, L.L.C.  
DSHS/Healthy Options/Tricare  
Informed Consent

Agreement to Pay  
(for a fee for service client)

*This form must be completed in full before providing a  
Non-covered services or item to a Medical Assistance client.*

Client Name: \_\_\_\_\_ ID NUMBER/PIC: \_\_\_\_\_

- I understand that the specific services listed below are not covered by my medical assistance program and are not included as part of another service, or have been determined by MAA not to be medically necessary.
- I choose to receive these specific services.
- I agree to pay for these specific services.

SPECIFIC SERVICES 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 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 this form and all my questions were answered to my satisfaction.

\_\_\_\_\_  
SIGNATURE OF CLIENT/PARENT/  
GUARDIAN/REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF PROVIDER

\_\_\_\_\_  
PROVIDER NUMBER

\_\_\_\_\_  
DATE