

## Non-Covered Health Services Disclosure Form

We appreciate your decision to choose our professional services for your health care needs. The health care services that we provide come with a financial responsibility on your part. This responsibility obligates you to pay for our services.

As a courtesy, we have contacted your health benefit plan and have been advised by them that the health care services we recommend will not be covered by the benefit plan. If you choose to receive these services you will be completely responsible for payment of the health services.

We collect payment for services at the time of service unless you have made other payment arrangements.

Patient Name: \_\_\_\_\_ Address: \_\_\_\_\_

Your Health Plan denied coverage for the following reason(s):

\_\_\_\_\_

Name of Health Plan:

Health Plan Contact Person / Phone #

\_\_\_\_\_

Proposed Health Care Services:

\_\_\_\_\_

I have read this disclosure regarding my financial responsibility for health care services provided to me or for the patient for whom I am financially responsible.

I understand that my health plan will not cover the health care services identified above.

I agree to pay the full amount of all charges for the health care services delivered to me or to the patient for whom I am financially responsible even though my health plan has determined that the plan will not provide benefits and/or that the plan disagrees with need for such services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to patient:  Self  Parent  Guardian  Other \_\_\_\_\_

Practitioner Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_