As your Physician, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that may not be covered by your health insurance provider. Let me reassure you that I will order only the test and treatments that I feel are necessary for your treatment and care. If you have any questions about whether or not a particular service is covered by your health benefits contract or if you have a deductible, it is your responsibility to contact your insurance company to inquire about your individual policy. You will be expected to pay for these uncovered services in full. If you have a deductible that has to be met you will be responsible for paying that amount. If your claim is turned over to a collection agency, you will be responsible for any fees.

If you do not have Blue Cross / Blue Shield the services may fall under your out of network benefits. Again it is your responsibility to inquire about your individual policy with your insurance company.

If you have any questions someone in our office will be able to assist you.
Thank you for your understanding.

I have read your policy and agree to pay for the services that are not covered by my benefits contract as indicated by my signature.

Signature:_____ Date:_____

Witness: _____ Date:_____

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