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PATIENT BILLING ACKNOWLEDGMENT: NON COVERED SERVICES

Under your health plan you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract.

For example, this may include items such as supplies, venipuncture when required more than once per day, and other services which require time such as phone consultations, emailing lab results, missed or cancelled appointments (less than 24 hours), etc.

The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products.

SERVICES TO BE PROVIDED:

PROVIDER	SUPPLY_____ PROCEDURE_____ DME_____ OTHER_____ Time frame from _____ through _____ Schedule/details _____ Provider Signature_____
PATIENT	I, _____, acknowledge that I have been told in advance by my provider that the services/product & or supplies listed above are not covered by my Health Plan. I agree to pay for these non-covered services. Patient/Guardian Signature:_____ Name Printed:_____ Date:_____

Office Staff initial:_____