NOTICE OF NON-COVERED WAIVER

PATIENT NAME DOB

INSURANCE CARRIER MEMBER #

CONDITION/DIAGNOSIS

PROCEDURE

ESTIMATED CHARGE

Your signature at the bottom of this form signifies that you understand that the services and/or supplies identified above may not be considered eligible for benefits (i.e. service may be determined not to be medically necessary, non-covered or investigational) by your health insurance carrier.

Your decision to have this service rendered and your signature below indicates that you understand that your health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services and supplies.

You will be responsible for payment in full at the conclusion of the visit and fully accept the fact that the charges incurred are out-of-pocket expenses and will not reimbursed by your insurance carrier.

This office will at no time, now or in the future, submit a claim to your insurance carrier as the provider has deemed the service to be not medically necessary under the terms of this practice's contract with your carrier.

PATIENT OR GUARDIAN SIGNATURE DATE

WITNESS SIGNATURE DATE

MAIN OFFICE 301 NE Knott Street, Portland, OR 97212 ◆ MILWAUKIE OFFICE 10330 SE 32nd Avenue, Milwaukie, OR 97222

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