NON-COVERED SERVICES

Non-Covered Routine Services Policy

As my patient, I want to provide you the best care possible. There may be certain Routine services that I feel are necessary for maintenance of good health that are Not covered by your insurance contract. You will be expected to pay for those services in full.

Let me reassure you that I will order only tests that I feel are necessary for your treatment and care.

If you have any questions, such as whether a particular service is covered or not, someone in out office will be happy to assist you. Thank you very much for your understanding.

_______________________________ _______________

Signature Date

I have read you policy and agree to pay for services not covered by my contract As indicated by my signature for each date above.