NOTICE OF POSSIBLE NON-COVERED SERVICES WAIVER

I ______________________________ understand that some services may not be eligible for benefits by my health insurance provider and I will be held responsible for these charges. I understand that my health insurance coverage has certain restrictions and limitations, such as non-covered service guidelines: (including but not limited to , Immunizations, Injections, Blood Work, Durable Medical Equipment, Holter Monitor, X-Rays, Minor Procedures or Physicals)

By signing this form I understand that I am agreeing in advance to receive services and will pay for the services rendered IF my insurance denies payment due to services not covered.

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(Patient Printed Name)

______________________________ ____________________

(Patient Signature) (Date)