Waiver of Insurance Billing for Private Pay Patients

Purpose of Form
This form is intended to document your decision to waive the use of your medical insurance for the services provided and to accept full financial responsibility for any and all charges incurred.

Waiver of Insurance Billing
By signing below, I acknowledge and agree to the following:

1. I am choosing not to have my medical insurance billed for the services provided by this healthcare provider.
2. I understand that by waiving insurance billing, I am responsible for the full cost of all services rendered at the time of service or as otherwise agreed upon.
3. I am aware that I may not be reimbursed by my insurance provider for services paid out-of-pocket.
4. I understand that this decision is voluntary, and I have the right to discuss this with my insurance provider or seek clarification from the clinic's billing department.
5. I acknowledge that some services provided may not be covered or reimbursable by my insurance provider under any circumstances.
6. I attest that I am not a recipient of Medicaid benefits.
7. I agree to notify the office of Dr. Alan F. Bain, D.O. if I decide to change this agreement prior to my next appointment

NEW PATIENT
New Patient IN OFFICE VISIT: $200
New Patient TELEHEALTH VISIT: $200
New Patient ALTERNATIVE MEDICINE | Homeopathy Visit: $227

ESTABLISHED PATIENT
Established Patient IN OFFICE VISIT: $150
Established Patient TELEHEALTH VISIT (Extended Visit): $150
Established Patient TELEHEALTH VISIT (Standard Visit): $100
Established Patient Rx REFILL VISIT: $50
Established Patient ALTERNATIVE MEDICINE | Homeopathy Visit: $227

Patient Acknowledgment

☐ I have read and fully understand the above statements. I voluntarily choose to waive the use of my medical insurance for the listed services and agree to be responsible for payment in full.

PATIENT NAME PRINTED | DATE OF BIRTH

PATIENT SIGNATURE | DATE