**NON PARTICIPATING INSURANCE**

We will file your claim for today, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. We are showing that we are not in network with your plan. If they deny this claim, you will then be responsible for the entire charge and will be billed.

Always verify with your insurance prior to visits to ensure there are no issues with a provider being paid by your plan.

Please sign below acknowledging your understanding of our policy.

Thank you!

Management

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Witness Date