DIVIDE CREEK, PC
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WAIVER OF NON-COVERED SERVICES

I, _____ understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by my health insurance carrier. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

SERVICES/SUPLLIES REQUESTED: _____

_____

_____

CONDITION/DIAGNOSIS: _____

_____

APPROXIMATE COST: _____

DATE OF SERVICE: _____

PATIENT NAME (if different from above): _____

PATIENT DATE OF BIRTH: _____

PATIENT/GUARDIAN SIGNATURE: _____

DATE: _____

OFFICE MANAGER SIGNATURE: _____

DATE: _____