Non-Covered Services Agreement

I, _____, being a patient of Dr. _____ located at_____, do hereby acknowledge that it has been explained to me that a certain portion of my care will not be covered under the terms of my Health Plan. The portion of care not covered is: _____

_____.

I acknowledge that I have been told ***in advance of treatment*** what portion of my care I will have to self-pay for and I agree to make financial arrangements with the aforementioned Provider to pay for these services myself.

Dated at _____,
(Office Name)

_____,
(Office Address)

this _____day of _____, 20_____.
(Date) (Month)

_____
(Patient Name - Print)

_____
(Patient Name - Signature)

Member I.D. # _____

Plan Name _____

If you feel you have not been offered alternatives that are within the benefit limits and/or allowance amount, or feel uncomfortable signing this agreement, please contact member services at (800) 508-6775.