NON-COVERED INSURANCE SERVICES

PATIENT: _____

As our patient, we would like to provide you with the best care possible. There may be certain routine services/procedures that we feel are necessary for the maintenance of good health that are not covered by your insurance provider, i.e. appliances, injections, or physical therapy. You will be expected to pay for those services in full at time of appointment or date or you may set up a payment plan that will fit both your financial situation and ours. We would like to assure you that we will order only those materials or services that are felt to be necessary for your best treatment and care.

If you have any question about your insurance provider's covered or non-covered services/procedures, such as whether a particular service, item, procedure is covered, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree to pay for services that may not be covered by my insurance provider by my contract as indicated by my signature below.

_____ _____

Print Name Date

_____ _____

Patient (Parent/Guardian) Signature Date