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CONSENT TO PAY FOR NON-COVERED SERVICES

Patient's Name: ______________________________

Provider's Name: ______________________________

I understand that my insurer will not pay for services that it determines are not medically necessary. My provider has advised me that my insurer is likely to deny payment for the following services:

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for the following reasons:

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If my insurer denies payment for the services identified above, then I agree to be personally and fully responsible for the payment. BY SIGNING THIS FORM, I **UNDERSTAND THAT I AM AGREEING TO PAY FOR THE SERVICES IDENTIFIED ABOVE IF MY INSURER DENIES PAYMENT BECAUSE THE SERVICES ARE NOT MEDICALLY NECESSARY.**

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Patient's Printed Name

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Patient's Signature or Parent's Signature if client is under 18 yrs. old Date

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Witness Signature Date