CONSENT TO PAY FOR NON-COVERED SERVICES

Patient's Name:

Provider's Name:

I understand that I will be responsible to pay all services rendered at OPAL Medical Clinic. Complete payment is needed at the time of service.

Medicare does not reimburse for services at this clinic. Although I may make a claim with my indemnity insurance (e.g. PPO if they cover out of network providers) my insurer may not pay for services that it determines are not medically necessary. My provider has advised me that my insurer can deny payment.

If my insurer denies payment for the services identified, 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 SERVICES. MY INSURER MAY SUBSEQUENTLY DENY PAYMENT BECAUSE THE SERVICES ARE DEEMED NOT MEDICALLY NECESSARY.

Patient's Printed Name:

Patient's Signature:

Date:

Witness Signature:

Date: