



Services Not Covered by Insurance

Some services and fees provided by this clinic are not covered by insurance companies.

I understand that payment for the listed services will be my responsibility.

Calling the after hours On-Call Doctor: \$50
No-show: \$50
Cancelling a visit with fewer than 24 hours notice: \$50
Medicinally items
Library books
Speciality Lab Testing

Other _____

Other _____

We ask that you please call your insurance to make sure our physicians and any referrals are covered under your plan. All insurance co-payments are required at the time of service per your agreement with your insurance carrier.

Please remember, our relationship is with you not your insurance carrier. We cannot guarantee benefits or take responsibility for balances not paid by your insurance.

All additional non-covered services and associated fees will be discussed on a case by case basis and agreed upon in writing prior to administration of said services.

Signature _____ **Date** _____

Printed name _____

Relationship(if signed by representative) _____