Disclosure/ Agreement

Patient Name_____ **Date_____/_____/_____**

Reason for Today's Visit

Per insurance guidelines, if your appointment is for a Routine Preventive Exam and you wish to discuss a problem, you may be billed (2) charges for the visit. Your insurance policy will dictate how the claim is processed.

- Routine Preventive Exam (I have NO medical complaint or significant problems/ abnormality that I am aware of)
- I have a problem/complaint that I wish to have evaluated/ treated by the Doctor

  My chief complaint is:_____
- My insurance plan covers Preventive Medical Services
- My insurance plan does not cover Preventive Medical Services
- I do not know if my insurance plan covers Preventive Medical Services
- Pregnancy
- Consultation:_____
- Follow-up:_____

I agree to pay for any and all medical services I receive from the doctors/ providers of this practice that my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive medical visits, my failure to secure a referral from my primary care physician). The office will file a claim on my behalf. However, if my insurance company refuses to pay, I will pay upon written/verbal notice of their refusal.

I further agree and understand that this office can only code and file a claim for my visit(s) with a diagnosis that was encountered and documented in my medical records. Thus to ask this office to change a diagnosis code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may constitute insurance fraud.

Patient/Guardian:_____

Witness/Staff:_____

This disclosure/ agreement form is provided with the understanding that the publisher is not engaged in rendering legal or accounting advice.