PATIENT WAIVER FOR NON-COVERED SERVICES

Patient Name: _____ DOB: _____

Your insurance does not pay for all your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your provider believes that the following service(s), while they might be not covered by your health insurance, are an important part of your care and recommends that you receive these services. Should you choose to receive these services, and your insurance plan does not cover, you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether you want to receive these items or services.

The services recommended by your provider are listed below:

92215 (1st Visit) – Level 5 Office/Outpatient Visit	$197.00
96112 – Autism Diagnostic Observation Schedule (ADOS)	$300.00
Discount for uncovered service	$-100.00
99215 (3rd Visit) – Level 5 Office/Outpatient Visit	$197.00

The total cost for the services/items recommended by your provider are: $ 594.00

I acknowledge that I have been informed in advance of receiving these services and that these services may not be covered by my health insurance plan - **or Trusted Doctors is not in-network with my health insurance plan**. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*