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Board Certified
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Disclosure/Agreement

Date:_____

Patient's Name:_____

Reason for Today's Visit

[] Routine Preventative Exam (I have no medical complaint or significant problem/abnormality that I am aware off).

[] I have a problem/complaint that I wish evaluated/treated by the doctor.

My Chief Complaint is:_____

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[] My insurance plan covers Preventative Medicine Services.

[] My insurance plan does not cover Preventative Medical Services.

[] I don't know if my insurance plan covers Preventative Medical Services.

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. This office will file a claim in my behalf,however if my insurance company denies payment for any reason (e.g. non-covered services, does not pay for preventative medicine visits, my failure to secure a referral from my primary care physician), I will pay for same upon written/verbal notice of their refusal. Failure to pay within 45 days of filing is for the purpose of this agreement, a refusal to pay.

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 record. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

In the event I do not pay for these or any other services provided to me when due, I agree to pay all cost of collection, including reasonable attorney fees, whether or not a law suit is commenced as part of the collection process.

By:_____
Patient (or responsible party if patient or minor)

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