

A.P.N.Y. PATIENT WAIVER FOR MEDICAL SERVICES

Patient's Name: _____ Date: _____

Please be advised that your insurance does not pay for all of your health care 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 if they are performed in our office.

Your physician believes that the following supplies and/or services are an important part of your child's care and recommends that you receive these supplies and/or services in our office in order to provide your child with the best care possible. However, since the services listed here are not considered to be a covered benefit under your health insurance if provided in our office, should you choose to receive these services, 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 or not you want to receive these items or services.

The services recommended by your physician are listed below:

_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____
_____	\$ _____

The total cost for the services/items recommended by your physician are:
\$ _____

I acknowledge that I have been informed in advance of receiving these services, and that these services are not covered by my health insurance plan if they are performed in the office. I have chosen to receive these services and understand that my insurance might have covered these services if performed elsewhere. I understand that I will be financially responsible for the charges indicated above. I understand that I may not submit this bill to my insurance carrier for future reimbursement. I agree that these services should be provided in my physician's office.

By signing this medical services waiver, I am hereby agreeing in advance, in writing, to accept full financial responsibility for all costs associated with these medical services described in this document.

Print Patient Name _____

Patient Signature (if applicable) _____

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 health record.