Disclosure/Agreement

Date: _____ Patient Name: _____

MR# _____ Date of Birth: _____

Reason for today's visit

- Routine Preventive Exam (I have no medical complaint or significant problem/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.

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 on my behalf, however, if my insurance company refuses to pay, for whatever reason (e.g., non-covered services, does not pay for preventive 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 code solely for the purpose of securing reimbursement from any insurance carrier is inappropriate and may result in a fraudulent act(s).

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

By: _____

Patient (or responsible party if minor)

Witness: _____