COMMUNITY CARE PHYSICIANS

MRN:

Waiver for Non Covered Services

You must make a choice about receiving these health care services or items.

We expect that your current insurance company_____may not pay for the item(s) or service(s) that are described below. The fact that your insurance may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended the service/item. However, at this particular time, your insurance may not pay for:

Items or Services:	**Reason:**
30 minute Behavioral Health visit	**Non Par**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

* Ask us to explain, if you don't understand why your insurance may not pay.
* Ask us how much these items or services will cost you (Estimated Cost: $ **40.00**), in case you have to pay for them yourself or through other insurance.
* *Please choose one option. Check one box. Sign and date your choice.*

☐	Option 1= Yes, I want to receive these items or services
☐	Option 2 = NO, I have decided not to receive these items or services.

_____ _____ _____

Date Patient's Name Signature of Patient/Patient's Guarantor