Prime Healthcare Providers PLLC

Dr. Phillip Weinstein – *General Practice*
Dr. Adam Weinstein – *Internal Medicine*

902 Frostwood, Suite 262 ~ Houston, Texas 77024
Tel: (713) 932-0118 Fax: (713) 932-8303

NON-COVERED SERVICES AGREEMENT

Patient Name: _____

Procedure(s): _____ CPT Code: _____

Date of Service: _____/_____/_____ Charge: $ _____

Your doctor has determined, that based on your medical condition, the above referenced tests **ARE MEDICALLY NECESSARY** and is recommending that you have them done.

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.**

Your insurance company will only pay for "covered services" as outlined in your individual insurance contract. We will make every effort, in advance of the scheduled date, to have your insurance company verify that these service(s) will be covered, however for whatever reason (pre-existing condition, high deductibles, patient co-payments, and/or patient co-insurance percentage responsibility, etc) they may not pay in full or deem that these service(s) are not a covered benefit under your plan provisions or limitations. Even though we are going to call on your behalf to verify your coverage, we encourage you to independently call them and make sure that they agree to cover and pay for these services. Based on their verification of coverage, and with the understanding that this/these procedure(s) are a covered service, we will file a claim to your insurance company, on your behalf. However, if your insurance company later denies these benefits and/or applies these benefits to your deductible, we will then bill you for the amount due.

In the event that you do not have insurance, you have not met your deductible or your insurance company does not cover these services(s), we expect payment in full at the time the service is rendered.

Your signature below is required before having these service(s) performed and indicates that you are aware of the reasons that these services are needed and the risks associated with not having them done. It also acknowledges that every opportunity was afforded to you, to ask questions and that all of them were answered to your satisfaction.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & 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.**
I have been made aware of the reasons that these services are needed and the risks associated with not having them done.

I understand that my insurance will not actually decide on whether to pay unless I actually receive these services first. Please submit my claim to my insurance company. I understand that you may bill me for items or services and that I may have to pay the bill now, while my insurance is making its decision. If my insurance does pay, you will refund to me any payments I made to you that are due to me. If my insurance denies payment, I agree to be personally and fully responsible for payment within 30 days of the billing date, unless payment arrangements are made prior to this agreement.

BY:_____ Date: _____
Patient Signature (or authorized representative)

Witness:_____ Date: _____
(*Office Use Only)*