

Disclosure / Agreement

Date: _____

Acct #: _____

Name: _____

Reason for Today's Visit

_____ ***Routine Preventive Exam*** (I have no medical complaint or significant problem or abnormality that I am aware of). **If my Provider recommends that I have a 3-day Hemocult (Fecal) test done and provides me with the testing kit, I understand I must return this sample within 45 days or I will be assessed a \$5.00 administrative charge for the supplies I was provided with. However, if I choose NOT to do this test, I will inform the Provider of my decision, and not take the testing kit with me.**

_____ ***I have a Problem/Complaint*** that I wish to have evaluated/treated by my Provider. 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 understand that this office will file a claim to my insurance plan on my behalf for these services. For non-participating insurance plans (the insurance reimburses to the patient directly). We will bill your insurance company ONE time as a courtesy to you. I also understand there will be an additional charge for the collection of my Screening Pap Smear today; that is separate from the office visit charge. If my insurance carrier refuses payment for preventive visits, or deems these services as non-covered benefits, I agree to pay for these services in full.

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 by my care provider. The policy of this office does not allow documented coding to be altered for the purpose of insurance reimbursement.

By my signature, I certify that I have read, understand and agree to the stipulations outlined above.

By: _____

Patient Signature (or Responsible Party for Minor)