PATIENT HEALTH INSURANCE WAIVER

I have requested services by a provider at First Choice Medical Group (FCMG). I understand that these services may not be covered by my insurance and that I may be responsible for charges incurred today for (service/CPT code) ___________________________, ***even if I elect to have my insurance billed first.***

☐ The **provider** performing the above services is **not a participating provider** with my health insurance. Therefore, these services are not covered by my policy.

_______ Bill insurance ____ Do not bill insurance (Elective Self Pay)

☐ The **scope of services** rendered by this **provider** may not be covered by my health insurance policy.

_______ Bill insurance ____ Do not bill insurance (Elective Self Pay)

☐ The appropriate **authorization** required by my health insurance policy **has not been obtained or has been denied by my insurance**. It is my personal decision to receive the services and understand I may be responsible for the charges in full.

______ Do not bill insurance (Elective Self Pay)

☐ No claim will be sent to my insurance since it is my personal **decision not to use my health insurance** benefits for the above service even though I understand that these services are considered covered by my policy. (Elective Self Pay)

Patient/Legal Representative's Signature

____ **DOB:** _______________ **Date:** ___________________

Printed Name and Relationship of Person Authorized to Sign for Patient

____

Name

____

Relationship

Insurance Waiver Explained by: ________________________ **Date** ____________________