

Date: _____

Account #: _____

Patient Name: _____

Date of Birth: _____

REASON FOR TODAY'S VISIT *(Please mark one of the following)*

1. **Routine annual exam (Preventive/Wellness) - - - - I have no medical complaint or problem**
- My insurance plan covers Preventive/Wellness Services**
 - My insurance plan does not cover Preventive/Wellness Services**
 - I do not know if my insurance plan covers Preventive/Wellness Services**
2. **I have a problem/complaint that I wish evaluated/treated by the doctor**

I agree to pay for any and all medical services I receive from the doctors/providers of this practice that my insurance company does not pay. (Examples below...)

- Example 1. Deductible, Co-insurance, and/or Non-covered service (s) as determined by insurance policy guidelines**
- Example 2. Non-covered preventive/wellness service(s) due to annual/yearly maximum has been reached**
- Example 3. Preventive/wellness service(s) not payable by insurance due to insurance policy guidelines do not cover service(s) as a preventive/wellness benefit**
- Example 4. Non-covered preventive/wellness service(s) due to insurance policy not having preventive/wellness coverage**

I further agree and understand that this office can only code and file a claim for my visits with a diagnosis that was encountered and documented in my medical records. Thus to ask this office to change a diagnosis solely for the purpose of securing reimbursement from an insurance carrier is inappropriate and may result in a fraudulent act.

Signature of Patient

and/or Parent, If Patient under 18

Date