NON-COVERED PODIATRY SERVICES CONSENT FORM

Dear Patient:

This letter is to clarify our policy regarding cosmetic and non-covered services. Cosmetic and non-covered services are those procedures and services deemed "not medically necessary" by the insurance company. Your insurance policy specifically states that procedures "not medically necessary" are not covered. This may include routine trimming of corn or calluses, the cutting of toenails, or the purchase of arch supports. This may also include removal of moles, skin tags and other benign growths that are non-irritants.

Since these procedures are not covered by your insurance, there may be other options you would like to consider. The first option is to do nothing. If however, you wish to have a non-covered procedure performed for cosmetic or other reasons, you can have that procedure done in our office or by any other physician. The cost should be explained prior to the procedure. At that time, you will be asked to sign the Disclosure Statement below to verify your understanding of your financial obligation for the procedure.

If you have any questions regarding your insurance benefits, you may contact your insurance carrier through their Customer Service Department. A copy of this signed letter will remain in your chart as proof of understanding.

As always, we strive to render the highest quality of care. Thank you for choosing our office. We pledge to continue to earn your trust and confidence.

I have read and understand the above information.

_____ _____

Patient Signature Date Print Name Date

DISCLOSURE STATEMENT

I am in acceptance that I will be responsible to pay full charges for this procedure. My signature indicates that I wish to receive non-covered services.

_____

Reason for non-covered service

_____ _____ _____

Approximate cost Patient Name Date

_____ _____

Patient Signature Date Print Name Date