Integrative Health Specialists
Notice of Non-Coverage

Please choose Section A or B

SECTION A

Integrative Health Specialists strives to ensure a clear understanding of your financial responsibility with respect to your office visits. This document is provided to you _____so that you understand that your medical services
Patient Name
are not covered by your insurance plan because we are not a participating provider in your medical plan.

*****Integrative Health Specialists is not credentialed with _____
your insurance company.

By placing my signature on this wavier form below, I acknowledge the following:

1. I am aware that Integrative Health Specialists is not credentialed with my insurance plan.
2. I understand that I will be responsible for all services provided by Integrative Health Specialists.
3. I am voluntarily choosing on behalf of my child/legal guardian to obtain the service or procedure from the non-participating facility/provider.

Signature of Patient, Parent (if patient under age 18) or Legal Guardian:
Printed name of Patient, Parent (if patient under age 18) or Legal Guardian:
Date

SECTION B

I understand that you take my insurance _____, but I am asking you **not to bill** my insurance carrier and I will pay in cash.

Signature of Patient, Parent (if patient under age 18) or Legal Guardian:
Printed name of Patient, Parent (if patient under age 18) or Legal Guardian: