LondonHealthCenter
community natural medicine

NON-COVERED SERVICES
PATIENT CONSENT FORM

I, _____ understand that the services and/or supplies listed
(Print Patient name and member ID number)
below may not be considered eligible for benefits (i.e. services and/or supplies may be determined to be *not* medically necessary, non-covered, or investigational) by Molina or Medicaid. I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements and non-covered services and/or supplies.

If I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

Services/Supplies:

Pager calls: $40-$60

No show or late cancellation (less than 24 hours) of appointment:

- $55 office appointment
- $10 vaccine appointment

Supplements: Variable cost.

If our office does not take your insurance, we will bill you for the visit: Variable cost.

_____	_____	_____
Patient name or legal guardian signature	Member Identification number	Date

_____	_____
Witness signature	Date

2376 Main Street ▪ Ferndale, WA 98248 ▪ (360) 384-2900 ▪ Fax (360) 384-2955