VirtualConsultMD

PATIENT INFORMATION & FINANCIAL POLICY

CO-PAYMENTS, DEDUCTIBLES, AND FEES:

- All co-payments, insurance deductibles, and fees for rendered services that are not covered by insurance are due at the time of service.
- We accept cash, personal checks, and all major credit cards (ex. VISA, MasterCard, etc.). Payments can also be accepted by phone and mail.

INSURANCE:

- Your insurance policy is a contract between you and your insurance company; Virtual Consult MD is not a part of this contract agreement. **It is your responsibility to know and understand the provisions, limits and requirements of your individual benefit plan(s).**
- As a professional courtesy, our office will file your insurance claim for you; however, we cannot guarantee benefits or payments. If your insurance carrier denies payment for rendered services, **you remain 100% financially responsible for payment of rendered services by our office**, regardless of any insurance company determination, quote, or misquote, except where prohibited by law or prior contractual agreement.
- **We must have accurate billing information at each visit** in order to process claims through your insurance carrier. **Please bring your current insurance card to each visit** and notify our office staff of any changes to your insurance coverage prior to the start of service. **If you fail to provide accurate information required to process your claim, you will be held responsible for any subsequent charges**.

BILLING STATEMENTS:

- The balance on your statement is due and payable upon receipt, and is past due if not paid within thirty (30) days. **Payments can be made in person, by phone, or by mail.**
- If the balance is not paid in full or other arrangements are not made with our office, then a $10.00 processing fee will be applied to each additional statement.

PAST DUE ACCOUNTS:

- If your account balance is overdue by sixty (60) days or more, with no attempt to set up a payment plan; all future appointments will be cancelled and you will not be given the opportunity to make an appointment until the outstanding balance has been paid.
- If your account is past due beyond ninety (90) days, it will be sent to a collection agency. You will be responsible for all fees incurred from the collection agency and/or attorney fees.
- Financial non-compliance may result in termination from the practice.

RETURNED CHECKS:

- **There is a $30.00 charge for checks returned for insufficient funds** and may require future payments to be paid in cash, credit, or money order.

BILLING QUESTIONS & CONCERNS:

- Virtual Consult MD has contracted with a third party billing agency, for billing and collection services. Should you have any billing questions and concerns, please contact our office at (812) 848-2322.

MEDICAL RECORDS, FORMS & LETTERS:

- **There is a $20.00 fee for medical records up to ten (10) pages in length**. Additional pages will be charged 50¢ per page thereafter. The fee must be paid prior to release of the medical records.
- **There is a minimum fee of $20.00 for the completion of forms or letters**. Additional charges may be applied on the nature and complexity of the form or letter. The minimum fee must be paid in order for the provider or their designees to begin the form or letter.
- We require **7-10 Business days** to process a request for medical records or to complete forms or letters. There is a $10.00 fee for "rush" requests, which must be paid at the time of said request.

PRESCRIPTIONS & PRESCRIPTION REFILLS:

- **Medication refills require a 72-hour notice**. We do not consider medication refills as an "emergency." Therefore, if you run out of medication over the weekend/holiday or forget to call for a medication refill, it will have to wait until the office reopens.
- We will not refill prescriptions for any patient who has not had adequate follow-up visits or who has not been seen at our office in the last three (3) months.
- You are responsible for all medications prescribed to you. **If your prescription is lost, misplaced, stolen, or run out early, please understand it may not be replaced**.

CANCELATION & NO SHOW POLICY:

- We strive to provide excellent medical care to you, your family and all of our patients. "No-shows" and "late cancellations" inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce such occurrences, **we request you give our office a 24 to 48-hour notice in the event you need to cancel and/or reschedule your appointment**.
- If you miss an appointment and have not contacted our office, this will be considered as a ***"No Show."*** If an appointment is canceled within 24-hours of your scheduled appointment, this will be considered as a ***"Late Cancelation."*** **You will be charged $60.00.** This fee will not be covered by your insurance company and must be paid prior to rescheduling your appointment. **Medicaid patients cannot be charged this fee, but can be dismissed from the office, after missing an appointment.**
- If you are more than ten (10) minutes late for an appointment, our office cannot guarantee that you will be seen and we have the right to reschedule your appointment.
- As a professional courtesy, our office makes reminder calls and/or texts for all appointment types, but it may not always be guaranteed. **It is ultimately the patient's responsibility to remember their scheduled appointments.**

DISMISSAL FROM THE PRACTICE:

- If you are "dismissed" or "terminated" from the practice, it means you can no longer schedule appointments; received medication refills, or consider Virtual Consult MD to be your healthcare provider. You will be required to find another practice for your medical services/needs.

  Common Reasons for Dismissal include, but not limited to:
  - *Failure to keep appointments, frequent cancelations and/or no-shows.*
  - *Non-compliance or failure to follow office instructions and/or policies.*
  - *Abusive behavior to office staff and/or other individuals within the office.*
  - *Failure to pay your medical bills.*

- If you are "dismissed" or "terminated" from the practice, we will send a formal written notification letter via certified mail to your last known address. We will send a copy of your medical records to your new healthcare provider as per your request; in accordance to our office medical record release policy.

ACKNOWLEDGEMENT & CONSENT

I have read and understand the "Patient Information and Financial Policy" for Virtual Consult MD and I agree to be bound by its terms. I agree to assign insurance payments to be made directly to Virtual Consult MD, for services rendered. I also understand and agree that such terms and conditions may be amended or subject to change.

_____ _____ /_____ /_____

Print Patient Name ***Date***

_____

Signature of Patient / Guardian

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PATIENT INTAKE FORM

Date: _____

I. Patient Information:

Child's Name: _____ DOB: _____/_____/_____ [mm/dd/yyyy] Sex: ☐ M ☐ F

Social Security Number: _____ – _____ – _____ Race: _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Mobile Number: _____

Email Address: _____

II. Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____ Mobile Number: _____

III. Insurance Information:

Primary Insurance Co Name: _____ Psychiatric Coverage: ☐ YES ☐ NO

Member ID #: _____ Group Number: _____ Co Payment: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Subscriber Information:

First Name: _____ Last Name: _____

Phone Number: _____ DOB: _____/_____/_____ [mm/dd/yyyy]

IV. Pharmacy Information:

Name: _____ Phone No: _____ Fax No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

V. PCP Contact Information:

Provider Name: _____ Phone No: _____ Fax No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

VI. Mental Health Provider Information:

Does your child currently have a Psychiatrist? ☐ YES ☐ NO If Yes, Provider Name: _____

Does your child currently have a Therapist? ☐ YES ☐ NO If Yes, Provider Name: _____

VII. Referral Source:

Source Name: _____ Contact #: _____

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FAMILY AND EDUCATION

I. EDUCATIONAL HISTORY:

School: _____ ☐ Public ☐ Private Grade level: _____ GPA/Average Grade: _____

Performance in School ☐ Excellent ☐ Above Average ☐ Average ☐ Below Average ☐ Poor

Ever held back? ☐ Yes ☐ No If Yes, which grades _____

Detention/suspensions? ☐ Yes ☐ No If Yes, explain: _____

Any bullying in school? ☐ Yes ☐ No If Yes, explain: _____

Does child have a 504 plan? ☐ Yes ☐ No If Yes, describe accommodations: _____

II. FAMILY HISTORY:

Child adopted? ☐ YES ☐ NO

Parents are: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED

If separated or divorced, what are the custody arrangements? _____

Household Members:

Name	Age	Relationship	Occupation/Grade
1			
2			
3			
4			
5			

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PATIENT MEDICAL HISTORY

I. Current Medication List:

Medication	Dosage	# Times/Day	Medication	Dosage	# Times/Day
1			6		
2			7		
3			8		
4			9		
5			10		

II. Allergies:

Medication	Reaction	Medication	Reaction
1		4	
2		5	
3		6	

III. Medical History: (Check All that Apply)

- ☐ Anemia / Blood Disease
- ☐ Asthma / Allergies
- ☐ Autoimmune (ex Lupus)
- ☐ Bone Disease
- ☐ Cancer / Tumor
- ☐ Colitis / Diverticulitis
- ☐ Diabetes
- ☐ Epilepsy / Seizure Dis
- ☐ Eye Disease / Problem
- ☐ Fatigue Fibromyalgia
- ☐ Headache / Migraine
- ☐ Heart Disease
- ☐ Kidney / Bladder Disease
- ☐ Menstrual Problems
- ☐ Myopathy / Muscular Dis
- ☐ Neurological Disorder
- ☐ Obesity
- ☐ Skin Trouble
- ☐ Sexual Transmitted Disease
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vasculitis / Vascular Dis
- ☐ Other: _____
- ☐ NONE

IV. Developmental History:

Pregnancy: ☐ NORMAL ☐ COMPLICATIONS: _____

Substance Abuse during pregnancy: ☐ None ☐ Alcohol ☐ Smoking ☐ Heroin ☐ Opiates ☐ Other: _____

Birth: ☐ FULL TERM ☐ PREMATURE. ☐ COMPLICATIONS: _____

Babies Health: ☐ HEALTHY ☐ COMPLICATIONS: _____

Developmental Therapy. ☐ NONE ☐ OCCUPATIONAL THERAPY ☐ SPEECH THERAPY OTHER: _____

V. Family Psych History:

Mother: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

Maternal Side: *(Grandparents, Aunts, & Uncles)* Psychiatric Problems: _____

Father: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

Paternal Side: *(Grandparents, Aunts, & Uncles)* Psychiatric Problems: _____

Sibling: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

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VI. Psychiatry History (Check All that Apply)

- ☐ Anxiety Disorder
- ☐ Attention Deficit Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Eating Disorder
- ☐ Mood Disorder
- ☐ Oppositional Defiant Disorder
- ☐ OCD
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ PTSD / Trauma
- ☐ Schizophrenia
- ☐ Sleep Disorder
- ☐ Substance Abuse Disorder
- ☐ Other: _____

VI. Psychiatry History Cont.… (Check YES or NO. If YES, Please Explain)

Does Child Have Any Prior Inpatient Admission? ☐ YES ☐ NO

i. When: _____ Where: _____ Why: _____

ii. When: _____ Where: _____ Why: _____

Does Child Have Any Past Suicide Attempt or Self-Injuries? ☐ YES ☐ NO

i. When: _____ Describe Action: _____

Has Child Ever Been Emotionally, Physically, or Sexually Abused? ☐ YES ☐ NO

VII. Social History:

Do You Have Any Religious Beliefs? ☐ YES ☐ NO If Yes, please explain: _____

Do You Have Any Legal Problems? ☐ YES ☐ NO If Yes, please explain: _____

Are You Sexually Active? ☐ YES ☐ NO

VIII. Substance Use History:

Do You Smoke Tobacco? ☐ YES ☐ NO If Yes, How Often? _____

If Yes, How Much? _____

Do You Drink Alcohol? ☐ YES ☐ NO If Yes, How Often? _____

If Yes, How Much? _____

In The Past 30 Days, Have You Been Prescribed Any of the Following Medications? *(Check All That Apply)*

- ☐ OPIATES *(Morphine, Oxycodone, Percocet, etc.)*
- ☐ SEDATIVES / "BENZO" *(Ativan, Klonopin, Valium, Xanax, etc.)*
- ☐ STIMULANTS *(Adderall, Ritalin, Vyvase, etc.)*
- ☐ NONE

In The Past 30 Days, Have You Used Any of the Following Substances? (*Check ALL That Apply*)

- ☐ COCAINE
- ☐ HEROIN
- ☐ MARIJUANA
- ☐ PCP / LSD
- ☐ NONE

INITIAL PSYCHIATRIC EVALUATION FORM

I. Current Symptoms: (Check All that Apply)

- [ ] Anger
- [ ] Binging
- [ ] Cannot Relax
- [ ] Changes in Weight
- [ ] Compulsions
- [ ] Concerned about Weight
- [ ] Decreased Energy
- [ ] Depression
- [ ] Difficulty Concentrating
- [ ] Difficulty Falling Asleep
- [ ] Difficulty Paying Attention
- [ ] Difficulty Staying Asleep
- [ ] Do Not Need Sleep
- [ ] Early Awakening
- [ ] Fearful
- [ ] Feeling Better off Dead
- [ ] Feeling on Top of the World
- [ ] Feeling Someone is After You
- [ ] Feeling Violent
- [ ] Feelings of Guilt
- [ ] Frustration
- [ ] Hearing Voices
- [ ] Helplessness
- [ ] Hopelessness
- [ ] Impulsivity
- [ ] Increased Energy
- [ ] Irritability
- [ ] Legal Problems
- [ ] Loss of Interest
- [ ] Mood Swings
- [ ] Obsessions
- [ ] Panic Attacks
- [ ] Purging
- [ ] Restlessness
- [ ] Seeing Things that Aren't There
- [ ] Sleeping All Day
- [ ] Social Anxiety
- [ ] Social Isolation
- [ ] Spending a lot of Money
- [ ] Using Drugs
- [ ] Worrying a Lot
- [ ] Other: _____ _____
- [ ] NONE OF THE ABOVE

II. Psychotropic Medication History: (Check All that Apply)

- [ ] Abilify
- [ ] Ambien
- [ ] Adderall
- [ ] Anafranil
- [ ] Antabuse
- [ ] Ascendin
- [ ] Atarax
- [ ] Ativan
- [ ] Buspar
- [ ] Campral
- [ ] Celexa
- [ ] Chloral hydrate
- [ ] Clonidine
- [ ] Clozaril
- [ ] Cogentin
- [ ] Concerta
- [ ] Cymbalta
- [ ] Dalmane
- [ ] Depakote
- [ ] Dexedrine
- [ ] Haldol
- [ ] Doral
- [ ] Effexor
- [ ] Elavil
- [ ] Fanapt
- [ ] Geodon
- [ ] Halcion
- [ ] Klonopin
- [ ] Invega
- [ ] Lamictal
- [ ] Latuda
- [ ] Lexapro
- [ ] Librium
- [ ] Lithium
- [ ] Lunesta
- [ ] Luvox
- [ ] Marplan
- [ ] Mellaril
- [ ] Methadone
- [ ] Miltown
- [ ] Nardil
- [ ] Norpramine
- [ ] Orap
- [ ] Pamelor
- [ ] Parnate
- [ ] Paxil
- [ ] Prosom
- [ ] Pristiq
- [ ] Prolixin
- [ ] Remeron
- [ ] Restoril
- [ ] Risperdal
- [ ] Ritilan
- [ ] Saphris
- [ ] Serax
- [ ] Seroquel
- [ ] Serzone
- [ ] Soma
- [ ] Sonata
- [ ] Stelazine
- [ ] Strattera
- [ ] Suboxone
- [ ] Symmetrel
- [ ] Tegretol
- [ ] Thorazine
- [ ] Tofranil
- [ ] Topomax
- [ ] Traxene
- [ ] Trazodone
- [ ] Trileptal
- [ ] Valium
- [ ] Vibryd
- [ ] Vistraril
- [ ] Vivitrol
- [ ] Wellbutrin
- [ ] Xanax
- [ ] Zoloft
- [ ] Zyprexa
- [ ] Other: _____
- [ ] NONE OF THE ABOVE

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often has your child been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
	For each question Choose ONE answer from the column			
Little interest or pleasure in doing things?	0 O	1 O	2 O	3 O
Feeling down, depressed, or hopeless?	0 O	1 O	2 O	3 O
Trouble falling or staying asleep, or sleeping too much?	0 O	1 O	2 O	3 O
Feeling tired or having little energy?	0 O	1 O	2 O	3 O
Poor appetite or overeating?	0 O	1 O	2 O	3 O
Feeling bad about yourself or that you are a failure or have let yourself or your family down?	0 O	1 O	2 O	3 O
Trouble concentrating on things, such as reading the newspaper or watching TV?	0 O	1 O	2 O	3 O
Moving or speaking so slowly that other people have noticed it? OR Being so fidgety or restless that you have been moving around a lot more than usual?	0 O	1 O	2 O	3 O
Thoughts that you would be better off dead, or of hurting yourself in some way?	0 O	1 O	2 O	3 O
	TOTAL SCORE			

GENERALIZED ANXIETY DISORDER QUESTIONNAIRE (GAD-7)

Over the last 2 weeks, how often has your child been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
	For each question Choose ONE answer from the column			
Feeling nervous, anxious or on edge?	0 O	1 O	2 O	3 O
Not being able to stop or control worrying?	0 O	1 O	2 O	3 O
Worrying too much about different things?	0 O	1 O	2 O	3 O
Trouble relaxing?	0 O	1 O	2 O	3 O
Being so restless that it is hard to sit still	0 O	1 O	2 O	3 O
Becoming easily annoyed or irritable?	0 O	1 O	2 O	3 O
Feeling afraid as if something awful might happen?	0 O	1 O	2 O	3 O
	TOTAL SCORE			

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ACKNOWLEDGEMENT & CONSENT

By signing below, I acknowledge that the information provided above is accurate and true. I consent to the use and disclosure of my health information to treat me and arrange for my medical care. I acknowledge that I have been informed of the privacy practice of this practice, and I have been informed that I must check my co-pay, deductible, and any limits to my benefits with my insurance company. I have also been informed of my responsibility for all collection costs, attorney and court costs, and any additional processing fees, if my account becomes delinquent.

_____ _____ /_____ /_____

Patient Name *Date*

_____

Signature of Patient/Guardian

Effective April 14,2003 the U.S. government regulators established a privacy rule; Health Information Portability and Accountability Act (HIPAA) & Governing Protected Patient Health Information (PHI). We are required by law to protect the privacy of health information that may reveal your identity, and provide you with this notice that describes the health information privacy practices of this practice. A copy of this notice is posted in our office.

PAYMENT IS DUE AT YOUR SESSION [CASH, CHECK, CREDIT CARDS (including HAS, HRA, MRA) ARE ACCEPTED

OFFICE USE: COMPLETED REGISTRATION PACKETS MUST INCLUDE:
1. PATIENT IN-TAKE FORM 2. HIPAA FORM 3. COPY OF PATIENT'S INSURANCE CARD 4. COPY OF LICENSE 5. PATIENT INFORMATION & FINANCIAL POLICY FORM 6. ABN FORM (COMPLETED BY MEDICARE BENEFICIARY ANNUALLY)

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PATIENT NAME: _____ **DATE OF BIRTH:** ____ /____ /_____

SECTION A: PRACTICE LOCATION INFORMATION

☐ **Virtual Consult MD, LLC**
4770 Covert Avenue, Suite 101
Evansville, Indiana – 47714
Tel: (812) 848-2322 / Fax: (812) 727-5469

☐ **Virtual Consult MD, LLC.**
109 US Highway 66 E, Suite 151
Tell City, Indiana – 47586
Tel: (812) 848-2322 / Fax: (812) 727-5469

☐ **Virtual Consult MD, LLC.**
11 NE 3rd St
Washington, IN 47501
Tel: (812) 848-2322 / Fax: (812) 727-5469

SECTION B: AUTHORIZED PERSON(S) OR ORGANIZATION(S) INFORMATION

I, abovementioned, authorize the release of my personal health information including any diagnosis, treatment, services rendered and/or claims payment information. I understand that any personal health information or other information released to the person or organization identified below may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This information may be released to: (*please print full name*)

☐ Spouse: _____ ☐ Organization: _____

☐ Parent: _____ ☐ Other: _____

☐ Child: _____ ☐ **INFORMATION IS NOT TO BE RELEASED TO ANYONE**

SECTION C: EMAIL OR TEXT USAGE FOR APPOINTMENT REMINDERS AND PERSONAL HEALTH INFORMATION

We may contact via email and/or text message in regards to upcoming appointment(s) and/or to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information. If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

____ to **Opt-Out** of receiving email or text from Virtual Consult MD, LLC; please initial your name

SECTION D: RELEASE OF PATIENT INFORMATION

I hereby freely, voluntarily and without coercion, authorize Virtual Consult MD, LLC listed above (SECTION A) to release my personal health information to the person(s) or organization(s) listed above (SECTION B). I understand the reason for disclosure is to facilitate continuity and coordination of care. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my written revocation to Virtual Consult MD, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This Release of Information will remain in effect until terminated by me, the abovementioned, or my legal representative, in writing. I also understand that I have a right to obtain a copy of this authorization.

PATIENT SIGNATURE: _____ **DATE:** _____

If applicable, Legal Representatives sign below: By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written that I am legally authorized to act on the Patient's / Member's behalf with respect to this authorization form.

NAME OF LEGAL REPRESENTATIVE: _____ **DATE:** _____

SIGNATURE OF LEGAL REPRESENTATIVE: _____

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☐ **Virtual Consult MD, LLC**
4770 Covert Avenue, Suite 101
Evansville, Indiana – 47714
Tel: (812) 848-2322 / Fax: (812) 727-5469

☐ **Virtual Consult MD, LLC.**
109 US Highway 66 E, Suite 151
Tell City, Indiana – 47586
Tel: (812) 848-2322 / Fax: (812) 727-5469

☐ **Virtual Consult MD, LLC.**
11 NE 3rd St
Washington, IN 47501
Tel: (812) 848-2322 / Fax: (812) 727-5469

A. Notifier: (*listed above)*

B. Patient Name: _____ C. Identification Number: _____

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If your Insurance Company does not pay for any of the procedure code/service listed in **Section D** below, you may have to pay. Your Insurance Company does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect your Insurance Company may not pay for the procedure code/service listed in **Section D** below.

D. Procedure Code / Services	E. Reason Insurance Company May Not Pay:	F. Estimated Cost
1. CPT Code 90971, 90792	1. Insurance does not pay for this procedure code for your condition	Any dollar amount ranging between $40 to $180 **Above mentioned applies to all procedure codes listed in (D)**
2. CPT Code 99202 – 99205	2. Insurance does not pay for this procedure code for your condition	
3. CPT Code 99212 – 99215	3. Insurance does not pay for this procedure code for your condition	
4. CPT Code 90832 – 90840	4. Insurance does not pay for this procedure code for your condition	
5. CPT Code 96101 – 96120	5. Insurance does not pay for this procedure code for your condition	
6. Other _____	6. Insurance does not pay for this procedure code for your condition	

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the procedure code/service in **Section D** listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but your Insurance Company cannot require us to do this.

G. OPTIONS: Please check only ONE box below (*our office cannot choose a box for you***)**

☐ **OPTION 1.** I want to receive the procedure code/service in **Section D** listed above. You may ask to be paid now, but I also want my Insurance Company billed for an official decision on payment. I understand that if my Insurance Company does not pay, I am responsible for payment, but **I can appeal to my Insurance Company.** If my Insurance Company does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want to receive the procedure code/service in **Section D** listed above, but do not bill my Insurance Company. You may ask to be paid now, as I am responsible for payment. **I cannot appeal if my Insurance Company is not billed**.

☐ **OPTION 3.** I don't want to receive the procedure code/service in **Section D** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if my Insurance Company would pay.**

H. ADDITIONAL INFORMATION:

This notice gives our opinion, not an official by your Insurance Company. If you have other questions on this notice, please contact your Insurance Company.

Signing below means that you have received and understand this notice. You also have the right to receive a copy.

I. Signature:	J. Date: