(Customize top of form with name, address & phone) *(Provide 1 copy to patient; keep original in your files.)*

Patient's Name:

NOTICE OF EXCLUSION FROM HEALTH PLAN BENEFITS

You need to make a choice about having ***(LIST SERVICE/PROCEDURE).*** This service is not a covered benefit and consequently your health plan will not pay for it. When you receive a service that is not a covered benefit, you are responsible to pay for it.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully. ***Ask us to explain, if you don't understand why your health care service plan won't pay.***

Your doctor has recommended (***describe service in detail providing options for patient consideration***).

You are responsible for all of the fees associated with a non-covered service. The charge for the surgeon's professional fee is $_____ and the charge for hospital or ASC facility fee is $_____.

Beneficiary Agreement
Accordingly, the undersigned accepts full financial responsibility for the non-covered services described above. _____ _____ Signature of patient or person acting on patient's behalf Date