PRIMARY CARE CLINIC

ADVANCE NOTICE OF WAIVER

"I understand that, in the opinion of my physician, the services or items that he/she has requested to be provided to me on _____ may not be covered as being *"Reasonable and Necessary"* for my care. I understand that my medical insurance determines the medical necessity of the services or items that I receive. I also understand and agree that I will be responsible for payment of these services or items if these services or items are determined *"Not Reasonable and Necessary"* for my care." By signing this form, I request the recommended services be provided to me.

"Comprendo que, segun la opinion de mi medico, es possible que mi seguro medico no cubra los servicios o las provisiones que mi medico recomiende el dia _____ por no considerarlos *"Razonables ni Medicamente Necesarios"* para mi salud. Comprendo que el Seguro Medico determina la necesidad medica de los servicios o de las provisiones que recibo. Tambien comprendo y acepto que tengo la responsabilidad de pagar los servicios or provisiones si despues se determina que esos servicios y provisiones no son *"Razonables ni Medicamente Necesarios"* para mi salud." Al firmar esta forma, yo pido que se me den los servicios que sean recomendado.

_____

Signature of Patient/Firma de Paciente

_____

Date/Fecha

_____

Acct. Number

_____

Witness/Testigo