PalosVerdesMedicalGroup

Consent to Pay for Non-Covered Services

(99213-99214-GQ) Telehealth Visit

I, ______________________________(Patient's Name or Guarantor), understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g. services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by my insurance. By signing this form, I understand that I am agreeing to pay for the services identified below if my insurer denies payment because the services are not medically necessary or covered.

Procedure/Service(s):

99213-Visit-Established Patient L3	$85.00
99214-Visit-Established Patient L4	$105.0
99215-Visit-Established Patient L5	$150.00

Date of Service: ____________

Patient's Printed Name ______________________________ Date____________

Patient's Signature ______________________________ Date____________

Guarantor Signature (if minor)______________________________ Date____________

Witness Signature ______________________________ Date____________

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