No – Insurance Agreement

Patient Name:_____

Patient's Date of Birth:_____

Purpose of Service: Health Education Consultation

What opting out of using your insurance means:

Your insurance will not be billed for the service indicated above, nor may you bill your insurance yourself. The medical records related to the service indicated above will not be released to any third party unless you sign a release of authorization or if required by law.

You are required to pay in full for the service indicated above as well as any future services for health education consultation.

Please ask any questions you have about this process before signing below.

Signing below means you have read this notice and will not use your insurance benefits for payment for this service. You agree to be financially responsible for the full cost of the service.

Signature:_____ Date:_____

Please return all forms to Wisdom & Wellness

Mail: Wisdom & Wellness, 11403 East Pinon Drive, Scottsdale, AZ 85262

Email: lavinconsult@gmail.com