BABAJIDE OGUNLANA, DPM, PLLC
West Houston Foot & Ankle Center

NON-COVERED SERVICES AGREEMENT

Patient Name _____ Date _____

As a member of _____

Insurance plan, I am aware of the responsibility that certain services provided by my physician may be considered non-covered or not necessary by my insurance plan.

If my insurance plan denies payment because the services rendered to me are considered non-covered or not medically necessary, I agree to be personally and fully responsible for payment of these services.

_____
Patient's Signature

_____
Parent/Guardian Signature (if patient is a minor)

_____
Parent / Guardian Printed Name Date

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