

Insurance Claim Filing Waiver

Date:

By my signature below, I _____ hereby request the office of Dr. XXXXXX not file an insurance claim to my healthcare insurance company _____ for services rendered to me on ____/____/____.

In lieu of filing an insurance claim on my behalf, I will pay for services rendered in full by cash, check or credit card.

Furthermore, I request that my medical records, procedure and diagnosis billing information related to this date of service referenced above remain confidential and not be released by my doctor to any insurance company without my written consent, except as otherwise required by law.

I understand and agree to the following:

- The confidentiality imposed by this request applies only to the date of service above, and only if payment is made in full at time of service. I will execute additional requests (and provide payment in full) as needed for subsequent services if I wish confidentiality for these subsequent visits.
- My information will still be made available as needed to other healthcare providers (e.g., doctors, hospitals, pharmacies) for purposes of treatment.

Print Name

Signature

Date signed