Authorization to Not File to Insurance Form

Date: _____/_____/_____
MRN:_____

Patient Name:_____ Patient Date of Birth: _____/_____/
_____

This authorization is in compliance with the HIPAA Omnibus Final Rule and states that you, the patient or responsible party, has requested Coastal Carolina Health Care, P.A. (CCHC) to **not** to bill health insurance carrier for the services listed below. By signing this agreement you acknowledge that **I requested the services listed below to not be submitted to my insurance company. I understand that I am responsible for paying the cost of these services on the date of service and am subject to all of CCHC's other self-pay policies and procedures**. I understand this authorization cannot be rescinded.

I request the following services to not be filed to insurance and I agree to pay in full:
_____
_____
_____
_____
_____

I have read this agreement and acknowledge the content of this notice by signing below.

_____ Date: _____/_____/
_____
Patient Signature (or legal guardian if minor patient)