HEALTHLINE MEDICAL GROUP
15211 VANOWEN ST. SUITE 105
VAN NUYS, CA. 91405

# ADVANCE NOTICE OF NON COVERED SERVICES

I understand that my insurance company will only pay for services that it determines to be "medically necessary" and which are "covered benefits". If payment is denied by my insurance company, I understand that I will be billed for those services and will be responsible for payment in full.

Signature ______________________ Date ______________

# WAIVER FORM

I, ______________________, acknowledge that if my insurance does not list me as "eligible" for coverage, then I will be responsible for payment in full of any medical services rendered to me.

Signature ______________________ Date ______________

*This applies to ALL insurances.