Vitalia
Holistic Health Centre

1836 Westlake Ave N. Ste. 201, Seattle, WA 98109
p 206.729.6100   f 206.352.9198

□ **JoAnna T Forwell, ND**
□ **Adam R Geiger, ND**

PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: ____________________________   Date: __________________

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

Non-covered services offered in our office are listed below:
Prolotherapy
Platelet Rich Plasma therapy
Prolozone therapy
Ultrasound guided injections for the above therapies.
Mesotherapy
Heidelberg gastric testing
IV nutrient therapy
Chelation therapy
Prescribed supplements
Vitamin D Testing
hCG diet set up and supplies
Phone/email consults with your practitioner except for reporting of lab results.

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name ______________________________________

Patient Signature ____

Name of Parent or Legal Guardian (if applicable)___________________________

Signature of Parent or Legal Guardian (if applicable)________________________

Date_________________

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*