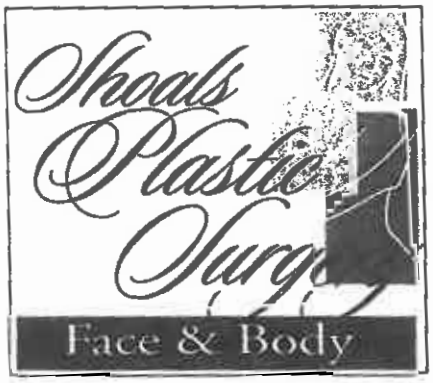

NOTIFICATION OF NON-COVERED SERVICES

Patient Name **DOB**

As a physician, I want to provide you with the best care possible. There are services that I feel are necessary for the treatment of your condition and maintenance of good health that are may not be covered by your insurance health benefits contract. You are expected to pay for those services in full. This includes some routine elective services.

If you have any questions about whether or not a particular service is covered by our health benefits contract, please contact your insurance Customer Service Department at the number listed on the back of your insurance ID card. Thank you for understanding.

All Lesion removals that insurance may deem not medically necessary

Patient Signature Date

*I have read your policy and agree to pay for the services outline above that are not covered by my contract as indicated.