Stella Ilyayeva MD Concierge Medicine

97-25 63rd Drive, 2nd Floor
Rego Park, NY 11374

Date:_____
Patient Name:_____
Patient Date of Birth:_____
Provider Name:_____

Non- Covered Service/ Item Waiver

There are items and services for which your Health Plan will not pay. Your Health Plan does not pay for all of your health care costs, but only pays for covered benefi ts. When you receive an item or service that is not a covered benefi t under your Health Plan, you will be responsible for payment personally.

The purpose of this Waiver is to assist you to make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

The Stella Ilyayeva MD Concierge Medicine Program charges a service fee of five-hundred dollars ($500) to all new participants and three-hundred dollars ($300) for all established participants at each scheduled encounter. This fee is likely to be considered a Non-Covered Benefi t by your Health Plan, despite the fact that Stella Ilyayeva MD may be a Network Provider for your Health Plan. By signing this Non-Covered Service Waiver form, you agree to waive your balance billing protection that might otherwise apply under the terms of your Health Plan and consent to Stella Ilyayeva MD collecting billed charges for Non-Covered services from you.

By voluntarily signing this Non-Covered Service/Item Waiver form ***prior to the provision of any item or service by Stella Ilyayeva MD Concierge Medicine***, I acknowledge that if any item or service as noted below is deemed Non-Covered by my Health Plan for any reason, including a determination of not Medically Necessary, I agree to be financially responsible to Stella Ilyayeva MD for the full amount due.

Total (Estimated) Billed Charges: _____

Patient Signature:_____

Patient Name (Printed)_____

Date:_____