

*The Choe  
Center  
for Facial Plastic Surgery*

INSURANCE WAIVER

Date of Service: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Your signature below signifies that you clearly understand that:

Dr. Kyle S. Choe is **NOT** a member of your managed care plan. Because the doctor is **NOT** on your insurance plan, the expense for your visits to this office will be your responsibility. This means you will have to pay the doctor's charges in full at the end of each visit. After you have paid for your visit, if you ask, you will be provided with a properly coded insurance form. Take this form and forward it to your managed care plan, keeping a copy for your records. Depending on the type of plan you have, you may be reimbursed only a percentage of the money you paid.

Know your plan benefits. Certain types of plans will not reimburse any money if the patient requests and seeks services from a physician that is **NOT** part of the plan or network.

Do not sign this form unless you positively understand the financial responsibilities of your visit, the charges you will have to pay, and the fact that you may not receive any of the money back from your insurance carrier.

**I understand all of the above and still want to receive services from the non-participating/out-of-network physician today.**

Signature of patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_