BELLA
health + wellness

Non-Covered Service Consent Form

I, _____

(Patient Name and Date of Birth), understand that the services and/or supplies listed below are not considered eligible for benefits and not deemed medically necessary and/or not covered by _____ (Health Insurance). Since I have chosen to obtain the service(s) listed below, I agree to be financially responsible for any and all related charges, and I agree to not request reimbursement from my medical insurance company.

*Functional Medicine Consultation and Investigation First Visit Cost (Outside of Insurance 1st hour charge) ***$977.00***

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient Signature Date