CONSENT FOR URINE DRUG SCREEN

Patient's Name: ____ Date: ____________________

Insurance: ____________________________________ Member DOB: _______________________

Your insurance may not pay for: 1) injections on the same day as an office visit, 2) for overutilization of an specific injection or 3) more than one injection on the same day.

Your provider believes that the following service(s), although not covered by your health insurance, are an important part of your pain management care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here may not be 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. If you decide to have more than one procedure performed on the same day, your health insurance plan may only pay for one procedure and the second procedure may be your financial responsibility. 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.

The services ordered by your provider are listed below:

Urine Drug Screen
Oral Swab Drug Screen

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

Patient Signature ____ 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.*