

**Non-Covered Services Waiver**

**Procedure Description - Physical Exam  
Well Exam ( Men / Women )  
Laboratory Work  
Injections**

**“ I have been notified by my physician that in my case my insurance is likely to deny payment for the services identified above and if my insurance denies payment, I Agree to be personally and fully responsible for the payments of these services.**

\_\_\_\_\_  
Signature of Beneficiary

\_\_\_\_\_  
Date