*ADAM urges you to consult your attorney and assumes no liability for use of this template/document. This document has **NOT** been reviewed by an attorney.*

Your Office Name

Restricted Visit

Requested Date(s) of Service: _____

Patient Name:_____Date of Birth: _____

I am requesting the restriction of my medical information regarding my visit on the above date(s) of service from being released to any other party, other than indicated below. I understand and agree to pay in full, at the time of service, for all physician charges associated with this date of service.

Should a prescription be necessary, I will be given a written script to handle directly with my pharmacy. I understand that I will need to advise the pharmacy that this should not go through my insurance, as this may compromise my desire to keep my visit restricted. (Typically a diagnosis will be associated with a prescription and the insurance carrier may contact the physician's office for clarification or change of script due to their formulary or prior authorization requirements.)

Should a biopsy be necessary, our practice will need to send the pathology out to a third party to be prepared and interpreted. This of course is considered part of the treatment and a description, size and clinical diagnosis of the lesion(s) is necessary for the performance of the test(s). We will ask the laboratory to bill you directly as a cash paying patient and when the result comes into the office, we will flag it as "restricted".

Should an additional procedure be necessary (ie. pathology was positive), and an additional surgery is required, this date of service will be considered part of the original treatment and restricted.

Additional Date of Service:_____Signed:_____Date: _____

The practice will post the full charges as a "Restricted Visit Charge" on a separate ledger not associated with the patient's account.

I understand and indemnify Your Office Name for any restricted information released by the pharmacy or laboratory.

I understand that once this document is signed, I cannot change my mind after that date of service in order to bill insurance. I will not be given any claim form to submit the charges myself. I also understand that I cannot restrict information on prior dates of service, because they have already been disclosed.

_____ _____

Signature of patient or legal guardian Date

_____

Printed name of patient or legal guardian