**Notice of Non-Covered Service:**
Fairview International Travel Clinic

Patient Name/MRN: _____ [Patient Label Here]

DOB: _____

Clinic: _____ Date of Service: _____

Health insurance plans may not cover travel clinic services. Your plan may not cover some services or items below. If your health insurance plan does not cover services, you will receive a bill for services.

- Before and after travel visit with a doctor
- Shots recommended for travel
- Office charges for shots.

See travel clinic estimated pricing sheet.

**If you have questions, call the business office phone number on your billing statement.**

I understand that this is an estimate of charges for today's visit. My payment may not cover services in full or I may receive a refund. The doctor and staff will review my chart to check that all services have been billed correctly. If there are added charges, I will receive a bill in the mail. If a refund is due, a check will be mailed to me.

**I have read and understand the above. I understand that if my insurance plan denies payment, I am responsible for payment upon receipt of a bill from Fairview.**

_____ _____
Signature of Patient or Guarantor Date Time

_____ _____
Witness Date Time

**Refusal of service:** I do **not** want to have the services listed above because I do not want to pay for them.

_____ _____
Signature of Patient or Guarantor Date Time

_____ _____
Witness Date Time