NY LONGEVITY
1100 FRANKLIN AVENUE, SUITE 203
GARDEN CITY, NY 1153

INSURED MEMBER TO WAIVE THE USE OF INSURANCE

Patient's Name: _____

DOB: _____

DOS: _____

By signing this form, I have elected to opt out of billing my insurance for the referenced date of service. I agree to pay PRACTICE at the time of service. I understand that I am responsible for paying the dollar amount designated by PRACTICE's fee schedule. I understand that PRACTICE will not seek or accept any type of reimbursement from my insurance carrier. I understand that once this form is signed, PRACTICE will not bill my insurance at a future date for the referenced date of service.

Signature: _____

Printed Name: _____

Date: _____