

Dr. Vicki L. Stone DPM
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Medical Insurance Disclaimer

I, _____ do hereby acknowledge an agreement to waive my rights of healthcare coverage under my benefits for non-covered services with Vicki L. Stone DPM. Furthermore, I understand and agree that with or without proper authorization, some procedures, services and products rendered to me by the above physician may not be covered by my health care benefits plan. The doctor's office is not responsible for determining coverage for services. I agree that I am completely responsible for payment in full for these non-covered services. I certify that I have read and do understand the contents of this disclaimer.

Signed: _____ Date: _____

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Signed: _____ Date: _____