



BABAJIDE OGUNLANA, DPM, PLLC
West Houston Foot & Ankle Center

NON-COVERED SERVICES AGREEMENT

Patient Name _____ Date _____

As a member of _____

Insurance plan, I am aware of the responsibility that certain services provided by my physician may be considered non-covered or not necessary by my insurance plan.

If my insurance plan denies payment because the services rendered to me are considered non-covered or not medically necessary, I agree to be personally and fully responsible for payment of these services.

Patient's Signature

Parent/Guardian Signature (if patient is a minor)

Parent / Guardian Printed Name Date

West Houston
1500 S. Dairy Ashford Suite 125
Houston, TX 77077

Southwest
7737 S W Freeway Suite 810
Houston, TX 77074