



ALABAMA ORTHOPAEDIC CLINIC, P.C.

**NON-COVERED SERVICES FOR BLUE CROSS BLUE SHIELD**

**PREFERRED CARE SUBSCRIBERS**

PATIENT: \_\_\_\_\_

As our patient, we would like to provide you with the best care possible. There may be certain routine services that we feel are necessary for the maintenance of good health that are not covered by your Blue Cross Preferred Care contract, i.e., appliances, injections, or physical therapy. You will be expected to pay for those services in full. We would like to assure you that we will order only those materials or services that are felt to be necessary for your best treatment/care.

If you have any questions about Blue Cross Preferred Care, such as whether a particular service/item is covered, someone in our office will be happy to assist you. Thank you for your understanding.

I have read your policy and agree to pay for services not covered by my contract as indicated by my signature.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient (Parent/Guardian) Signature