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

Phone: 281-558-9090 • Fax: 281-558-9093 • www.DrOgunlana.com