

**1040 Edgewater Corp Parkway, #104**

**Indian Land, SC 29707**

**(803) 548-2310 (Phone)**

**(803)548-2314 (Fax)**

[**www.revlismedical.com**](http://www.revlismedical.com)

CONSENT AND AGREEMENT WITH PATIENTS FOR ANY OUT OF NETWORK SERVICES PERFORMED AT REVLIS MEDICAL

We are happy to bill your insurance company for services performed in our office.  However, there may be times where we can only bill OON.  Please be aware that in some instances, since, Michael McKeown, DC and Heather Shiflett, PA-C are an out-of-network provider for some plans, your insurance company may issue the patient the check for the services performed.

We ask that by you signing below, you recognize that when you receive the check from the insurance company, you please sign it over to our office and we will subsequently credit your account accordingly.

In the event that you receive the check, and you choose to keep the money, we will balance bill for the amount owed.

Please open all correspondence from your insurance company, as it is difficult to recognize that a check may be enclosed.

We greatly appreciate your cooperation in this matter and are happy to provide these services to you.

If you have any questions, please feel free to contact us immediately.

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_