Advanced Program Acknowledgement

I, ________________________, acknowledge that I have been offered the Diamond Headache Clinic Advanced Program. The program has been fully explained to me and I have had the opportunity to ask questions.

I am declining enrollment in the Advanced Program. I acknowledge that if utilized, services which would otherwise be covered by the Advanced Program will be billed to me at the following rates:

Physician/ PA Electronic management and evaluation	$50.00
Physician/ PA Telephone Evaluation, 5 – 10 mins	$50.00
Physician/ PA Telephone Evaluation, 11 – 20 mins	$100.00
Physician/ PA Telephone Evaluation, 21 – 30 mins	$150.00

Furthermore, I acknowledge that such services are most likely not reimbursable by my insurance or Medicare. Please confirm with your insurance and/ or Medicare.

Print Name	**Date of Birth**
Signature	**Date**

Revised: 7/28/2014