HARLINGEN FOOT AND ANKLE CENTER
597 W. SESAME DRIVE, STE G
HARLINGEN TEXAS 78550
956-365-3334
DR. RAUL O. MALDONADO

Acknowledgement for Non-Covered Services:

Medical services & care which MAY NOT be covered by_____
(insurance name)
I understand that , any services or items requested and/or provided by Dr Raul Maldonado and or associates on _____ **may not** be
(Date)
considered reasonable or medically necessary for my care by the Texas Medical Assistant program or any Health insurance agents. I also understand that I **will be** responsible for payment of services or items provided that are determined by the Texas Department of Human Services or any Health insuring agents not to be reasonable or medically necessary for my care.
Services or items not covered :

Comprendo que sera posible que _____(nombre de aseguro) **no cubra** (pago de) servicios o provisiones que Dr Raul Maldonado o los associados, me haigan solicitado o yo haiga recibido el dia _____ por razon que el Departamento De Assistencia Medica de Tejas no los considera razonable medicamente necesario para mi salud. Tambien comprendo que **sera mi** responsibilidad pagar estos servicios provisiones solicitados o recibidos que el Departamento de Servicios Humanos de Tejas determina que no son razonables o necesarios para mi salud.
Servicios que no estan cubiertos:

Patient's signature/Date Witness/Staff signature/Date