



The Department of Executive Health offers services designed to help you successfully manage your health. Specifically, our program is aimed at promoting wellness and targeting, reducing and removing health risks. The executive physical core assessment (\$1,346), general fitness assessment (\$225), personal and executive coaching (\$341), and retinal fundus photography (\$286) and any service marked with an asterisk (\*) are not billable to insurance. By signing this waiver, you accept full responsibility for payment of any nonbillable services and screening studies not covered by your insurance carrier. Billing insurance does not guarantee coverage. Services billed to insurance list the diagnosis code used. Payment for self-pay services is requested before or on the date of service.

Table with 3 columns: Service Name, Women, Men. Rows include: RECOMMENDED CORE SERVICES NOT BILLED TO INSURANCE (Scheduling, Retinal fundus photography, General fitness assessment, Personal and executive coaching), SERVICES NOT BILLED TO INSURANCE DEPENDENT UPON AGE AND/OR RISK FACTORS (Coronary calcium score test\*, Noninvasive vascular screening\*, Low-dose radiation CT lung scan\*), CORE SERVICES BILLED TO INSURANCE (Laboratory panel, Prostate-specific antigen, Hepatitis C screening, HIV screening, Hearing test, Spirometry, Electrocardiogram, Body composition, Mammogram), SERVICES BILLED TO INSURANCE DEPENDENT UPON AGE AND/OR RISK FACTORS (Exercise stress test, Bone densitometry, Chest x-ray, Pap smear, HPV screening).

Table with 2 columns: Service Name, Price. Rows include: Additional Screening Services (Vaccinations, Screening colonoscopy, Additional appointment requests).

I have been notified that the executive physical assessment (\$1,346), general fitness assessment (\$225), personal and executive coaching (\$341), and retinal fundus photography (\$286), and any service marked with an asterisk (\*) are not billable to insurance. My insurance carrier is likely to provide only limited coverage for screening studies. Pricing is subject to change. I agree to be personally and fully financially responsible for my Executive Health Program and for any services not fully covered by my insurance.

Print name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_