Western Washington Medical Group
Arthritis Clinic

1909 214th Street SE, Suite 211

Bothell, WA 98021

Non-Insurance Covered Expenses for Physician and Non-physician Providers

Policies about services not usually covered by insurance

Non-Direct Care Billing Sheet

Name: _____ Date: _____

There are a number of services or activities you may request or require which are not usually covered by your insurance plan. These services include reports, forms, letters, and extended telephone conversations such as to an attorney, employer, etc. These services require your private payment, and will not be submitted to your insurance carrier.

Physician provider private pay services are charged based on an hourly rate of $300 per hour. Non-physician provider private pay services are charged based on an hourly rate of $150 per hour.

All physician provider activities that are non-health care related and in the service of legal activity for a patient represented by an attorney or legal firm, are billed at $450 per hour and $225 for a non-physician provider.

Please understand these charges before you request them. Some forms may require special evaluations prior to completion, e.g. disability forms, which ask for physical, cognitive, or psychological limitations. These evaluations may also require payment if not covered by insurance.

The following is an example of estimated charges. However, charges will be based on actual time spent.

FORMS:	**Physician**	**Non-Physician**
___ Simple form (not requiring chart). *Est. time 10 minutes*	$50	$25
___ Moderately complex form (one page, requires review and Professional opinion.) *Est. time 15 minutes*	$75	$37.50
___ Annual disability reapplication form (review and update) *Est. time 20 mins*	$100	$50
___ Complex form (2 or more pages with chart review) *Est. time 30 mins* *Est. time 30 minutes*	$150	$75
LETTERS:		
___ General letter (minimal chart review)	$100	$50
___ Disability letter (moderate chart review)	$150	$75
___ Time Reviewing records ____ @ ___ $300/hour; ___ $150/hour	$300	$150

LEGAL ACTIVITY: PLEASE HAVE YOUR ATTORNEY CONTACT US FOR A COMPLETE SCHEDULE OF LEGAL FEES AND POLICIES

Patient is aware of fees and has agreed to pay private for these non-insurance covered services.

Patient Signature: _____ Date: _____