



University Medical Practice Associates
Travel Medicine Program

Thank you for choosing our Travel Medicine program for your pre-travel counseling and vaccinations. Please be aware that most insurance companies **do not cover** the cost of the travel consultation and any vaccinations that you may receive. It is our policy to collect full payment when these services are rendered. Please provide us with your insurance information so that we may submit a claim on your behalf. If we receive payment directly from your insurance company you will be reimbursed.

I have read the above and understand that I am responsible for payment at the time services are rendered. I also understand that I am entitled to a refund if my insurance company pays the claim to University Medical Practice Associates.

Patient/ Responsible Party's Name: _____

Signature: _____ Date: _____

OR

I am already aware that my insurance coverage will not pay for these services. I do not wish to submit my insurance information for billing.

Patient/ Responsible Party's Name: _____

Signature: _____ Date: _____