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INSURANCE WAIVER

We do not verify eligibility with your insurance company. Authorization does not guarantee eligibility with your insurance company. In the event you are found ineligible for medical services, you will be responsible for payment in full.

_____	_____
Patient Name	Subscriber Name
_____	_____
Insurance Company Name	Medical Group Name
_____	_____
Subscriber ID	Employer Name

I understand that if I am found ineligible for medical services rendered by this provider, I will be financially responsible.

_____	**X**_____
Date	Signature of Patient/Legal Representative

Rev: January, 2008