INSURANCE WAIVER

I, _____,
Name of patient

UNDERSTAND THAT I AM ELIGIBLE FOR BENEFITS WITH

_____ AS OF _____.
Primary Insurance Carrier Effective date
(if NO insurance, please write "None" on form)

SUBSCRIBER NAME:_____

SUBSCRIBER DATE OF BIRTH_____

SS#:_____

GRP.#_____

_____ AS OF _____.
Secondary Insurance Carrier Effective date
(if NONE, please write "None" on form)

SUBSCRIBER NAME: _____

SS#: _____ SUBSCRIBER DOB:_____

GRP#: _____

I UNDERSTAND THAT IN THE CASE OF INELIGIBILITY, DENIAL, NON OR PARTIAL PAYMENT, I AM RESPONSIBLE FOR THE PAYMENT OF MY ACCOUNT.

_____ DATE_____
Responsible Party Signature