Financial Responsibility / Waiver Form

Dear Patient:

Positive verification of your coverage cannot always be made at the time of service. You will receive services with the understanding that in the event your coverage is not effective, you will be billed and held financially responsible for these services rendered.

Patient's Name	Insurance Carrier
Subscriber's Name	Employer / Group
Permanent Address	Group Policy Number
City, State, Zip	Telephone Number

I have read the above and understand my possible financial responsibility of services rendered and hereby affix my signature as an acknowledgment of this understanding.

Patient's Signature	Date
Witness Signature	Date

Place a copy of patient's driver's license below if not on file in chart.