

INSURANCE CARD WAIVER

We request that you fill out this sheet since your insurance card is not available today.

Patient Name: _____

Membership Number: _____ Date of

Visit: _____

I agree to be responsible for all charges incurred during this visit, should it be determined that I or my dependent(s) are not eligible for benefits.

Signature: _____ Date: _____ Print

Name: _____

Please return this form to the receptionist.

rev. 9/2007