Waiver of Insurance

Planned Procedure: ___________________________________

Date of Planned Procedure: _____________________________

By signing below, you consent (agree) that:

- I understand that my services may be covered by my insurance. It is my wish to waive my insurance coverage and pay at the time of service.

- I also understand that by waiving my insurance coverage, I release the physician and facility from any responsibility set forth in the insurance contract as a participating physician and/or facility for this procedure.

- I further agree I will not file a claim in my own behalf to my insurance company.

____
Print Name

______________________________ ____________________
Signature Date