

ROUTINE SERVICE WAIVER

You are scheduled for an annual exam today in our office. Please be advised that this is the way your insurance will be billed. If your insurance does not cover routine benefits, you will be expected to pay the balance in full today or within thirty days of notification from our office.

You may incur additional charges for services associated with our office such as lab, x-ray, etc.

We cannot bill your visit any other way when you schedule an annual exam, due to chart audits with insurance companies.

By signing, you acknowledge that you accept full responsibility for the charges, if your insurance does not cover these services.

Patient Signature _____

Date _____