PLEASE COMPLETE BEFORE BEING SEEN TODAY

WAIVER FORM

I understand that eligibility for my current insurance cannot be confirmed and verified at this time. On behalf of the patient, I wish to request medical services from Pediatric Dermatology of North Texas today.

If it is determined that the patient is not eligible for coverage, I understand that I will be responsible for payment of services provided today.

_____

Patient Name Date of Birth

_____

Responsible Party (please print) Signature

Date: _____

COPAY ON CARD? _____ Y _____ N AMOUNT$_____

DEDUCTIBLE: $ _____ per Responsible party

AMOUNT MET $ _____ per Responsible party

You will be required to pay in full for today's visit. If there is an Office visit copay on your card we will collect that for the copay. If not, we will collect towards your deductible. Same applies to a procedure done today we will collect toward the deductible.

Thank you,

Pediatric Dermatology of North Texas, PA
PDP of Texas, PLLC