PRIMECARE PEDIATRICS
3229 Hwy 34 East, Ste 103
Newnan, GA 30265
Ph. (770) 251-5253; Fax (770) 251-5254

Medical Record #:_____________

Date: __/___/_______

INSURANCE WAIVER

PATIENT'S NAME: *(Last)* *(First)* *(Middle)*	**DOB:** ____/____/_______	**AGE/SEX** ______

Insurance Company: ____

Policy Number: ____

I hereby acknowledge that if PrimeCare Pediatrics is unable to obtain authorization from my insurance company to cover the charges for the services received on this date of service, then I understand and agree that I will bear all responsibility for payment in FULL for all services rendered by PrimeCare Pediatrics.

Name of Parent or Guardian: ____ (Please print)
(Last) *(Middle Initial)* *(First)*

Relationship to Child/Children: _________________________________

Signature of Parent or Guardian: _________________________________

Date: ____________________________________