

KIDS FIRST PEDIATRIC PARTNERS
INSURANCE WAIVER OF LIABILITY FORM

Patient Name: _____

Date of Birth: _____

Insurance Co: _____

ID#: _____

Your health insurance carrier may or may not cover all services provided by your doctor. Some of these services may include, but are not limited to, vaccines, developmental screenings, vision screenings, hearing screenings, strep test, flu test and urine dips.

If your insurance does NOT pay for these services, by signing this form you acknowledge that you will be fully responsible for any remaining balance.

This form serves as a notice that some services may not be covered; it is not an official decision by your insurance carrier. If you have any questions about covered services please contact your insurance.

By signing below you acknowledge that you have received and understand this notice.

Responsible Party

Date