PATIENT WAIVER

I understand and agree that I am financially responsible for any charges not covered by my insurance carrier for this visit. This includes, but is not limited to, co-insurances, co-payments, deductibles and charges not covered by your insurance carrier (for instance, some immunizations and hearing and vision screening). Please be aware that policies vary among insurance carriers. There may be additional charges for disease-related matters addressed during a well-child check up. I also understand and agree that if my insurance carrier notifies NOVA Pediatrics that my child is not covered, has no well-child coverage, or has exceeded well-child coverage, I will be financially responsible for the entire charge and will pay promptly upon receipt of the statement. I also verify that I have updated my demographic and insurance information.

SIGNATURE	PATIENT'S NAME	DATE