Rose City Pediatrics Medical Group

Eligibility Waiver Form

I, ______________________________________hereby certify that I am eligible for
(Name of insurance subscriber)

______________________________________ benefits that are effective beginning
(Name of insurance company)

_____________________ and which are in force today.
(Date insurance coverage began)

I have chosen ROSE CITY PEDIATRICS MEDICAL GROUP to be my medical provider. I understand and agree that regardless of any insurance coverage, I am personally responsible for any and all charges related to services provided to either myself or my children. I agree to pay in full for all services received within 30 calendar days of receiving a bill from ROSE CITY PEDIATRICS MEDICAL GROUP. I understand and agree that I will present my/my child's insurance card as well as a suitable picture ID such as a California drivers' license or passport in order to be eligible to receive credit privileges, and further understand and agree that if these conditions are not met I may be required to pay in full for all services at the time they are provided.

______________________________________ _________________________
Signature of patient or responsible party **Date**

____
Printed name of patient or responsible party

____
Subscriber/responsible party social security number

____
Printed name of patient if different from above

____
Patient/child social security number
(required by some plans for claims submission. Child social security number will not be used for any other reason)_