Wakefield Pediatric Associates

15 Richardson Avenue, Wakefield, MA 01880
Telephone: (781) 245-2203 Fax: (781) 245-7303

Insurance Waiver

Date: ___________________

Patient Name: _______________________________

Insurance: __________________________________

As financial guarantor for the above named patient, I understand I am fully financially responsible for all charges not covered by my insurance.

I understand that it is my responsibility to select Dr. Gorlovsky or Dr. Wang as my child's primary care physician (PCP) for insurance company. I am responsible for correcting the PCP and agree that I am fully financially responsible for all denied or rejected claims.

I understand it is my sole responsibility to add my child to my insurance policy.

_____________________________ _________________

Name Date