Elite Cardiac & Vascular Care

HEALTHCARE ELIGIBILITY WAIVER AND FINANCIAL RESPONSIBILITY

Patient Name: _____

Health Plan: _____

Referring Physician Name: _____

Rendering Physician Name: _____

The patient or patient's legal representative hereby certifies that he/she is eligible for health plan benefits coverage and has chosen the above stated physician as the provider of his/her health care.

The patient or patient's legal representative understands that he/she is responsible for any co-pay and/or deductible and also if patient is found ineligible for coverage of plan benefits, he/she is financially reponsible for all costs and expenses incurred during the delivery of health services and agrees to pay these charges to the physician accordingly.

Please notice that there is going to be a $25.00 fee for any returned checks.

Print Patient's Name: _____

Patient's Signature: _____ Date: _____

Signature of Legal Representative: _____ Relationship to Patient: _____