Spring Pediatrics

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WAIVER FOR MEDICAL SERVICES

I have been informed that the medical services (Physical Exam, Office Visit, Immunizations, Lab Tests, and/or others) provided today at Spring Pediatrics to …… may not be covered by his/her or my insurance carrier.

Spring Pediatrics office staff has fully explained to me the options available to me to obtain these medical services.

I have asked my doctor to provide the above medical services to …… and I agree to be responsible to pay for all related charges.

The amount will be calculated after all services are rendered.

I agree to pay the full amount of today's visit.

_____
Patient's Printed Name

_____
Parent/Guardian's Printed Name

_____
Parent/Guardian's Signature

_____
Date