

JEFFERSON PRIMARY CARE
121 W. 3rd Avenue
Ranson, WV 25438

INSURANCE INFORMATION WAIVER

Date of Service _____
Patient Name _____
Referring Physician _____
Insurance Company _____
Copay _____

- I understand that I am contractually obligated with my insurance company to pay a co-payment, co-insurance and/or a deductible for today's services. I did not bring my portion for services rendered today and I understand that I must pay my portion within 24 hours.

If I do not pay my portion, I understand that I may be sent to collection and my insurance company can be contacted to inform them that I have not complied with my contract.

- I do not have my insurance card with me and I must bring it in by the end of business today. I understand that if I do not supply my insurance card I will be responsible for all charges within 10 days of receipt of bill.

Patient signature

Date

Witness

Title