PATIENT WAIVER FORM

Patricia Korber, M.D.

I hereby attest that I am an eligible member of a contracted Health Plan as noted below.

I agree that should it be determined that I am ineligible for coverage or services are denied by my Health Plan, that I will be responsible for payment to Patricia Korber, M.D. or their agents for those services deemed disallowed, ineligible or not covered.

HEALTH PLAN:_____

NAME OF PATIENT:_____

NAME OF SUBSCRIBER:_____

SIGNATURE:_____DATE:_____