Acorn Health Services
Phone: 508-691-6086
Fax: 508-691-6089

Insurance Waiver

Date:

I am a member enrolled in _________________________.

I acknowledge that I have voluntarily sought the services of Acorn Health Services, PC and that I accept full responsibility for paying these services provided today by the above named provider if my insurance does not cover my services. This includes copays and any unmet deductibles (dictated by my insurance plan).

I understand that this statement is not an acceptance of financial responsibility for any services other that those provided or ordered today.

_____________________________	_____________________________
Patient's Name (Print)	Patient's Insurance ID number
_____________________________	_____________________________
Patient's or Guardian's Signature	Today's Date

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Parent or Guardian's Name (Print)
(if patient is under 18 year of age)