Burkhart
Pediatric &
Adolescent
Dermatology

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Insurance Coverage Waiver Form

I understand that my eligibility for coverage by (Insurance Company) _____ cannot be confirmed at this time. I wish to receive medical service from Burkhart Pediatric & Adolescent Dermatology, PLLC. If the practice determines that I am not eligible for insurance coverage, I understand that I will be responsible for payment of all services provided.

Signature of Patient or Legal Guardian (if under 18 years of age):

_____ Date: _____