WAVIER AND RELEASE

INSURANCE (Any and All)

I AUTHORIZE DAVIS SQUARE FAMILY PRATICE TO:

1) Furnish and medical information to the insurance carriers concerning my dependents or myself, for coordination of medical care or benefit determination.

2) Receive all payments for medical services rendered to my dependants or myself.

I understand that I am financially responsible for all amounts uncovered by the insurance and any copayment at the time of the visit.

Signature: ______________________________________ Date: ____________________

SELF PAY

I understand that I am financially responsible to pay for any charges incurred by my dependents or myself for medical services rendered to Davis Square Family Practice.

Signature: ______________________________________ Date: ____________________