

RAMAPO VALLEY OB/GYN - PC

PATIENT WAIVER - FINANCIAL CONSENT

By my signature below, I acknowledge that I have requested an annual Well Exam from RAMAPO VALLEY OB/GYN - PC. If my insurance company does not provide coverage and reimbursement of such services, I agree to be personally responsible for payment of such services.

Signature of Patient

Date

FOR REFUSAL OF SERVICE

By my signature below, I acknowledge that my physician has recommended an annual well exam and I am making an informed decision in refusing such service.

Signature of Patient

Date