Financial Waiver

Date: _____ Patient: _____

Dos: _____

Reason for financial waiver:

_____ Patient has a new insurance but does not have the card yet

_____ Today's service is considered "non emergency" and will not be covered by Indiana Medicaid

_____ Vanderbilt Assessment forms may not be covered by your insurance

_____ Medicaid not eligible

I agree to take financial responsibility for the above and accept full responsibility for payment of these charges.

_____ _____

Patient/Guarantor Signature Date

_____

Biller's signature