



ENT of Georgia Insurance Coverage and Referral Waiver

I understand that my eligibility for coverage by _____ has not been verified at the time of my appointment, but I want to receive medical service from Dr. _____.

I am aware that when the insurance is finally verified, there is a disclaimer, which states that they do not guarantee payments, even though I may be eligible for benefits at the time of service. If it is determined that I am not eligible for coverage or that the medical services are not covered, I understand that I will be responsible for payment of all services provided.

I understand that if my insurance company requires a referral, and that referral has not been received before my appointment date, I agree to pay for all services rendered on the day of the visit.

Signature: _____

Name: _____
(Please Print)

Date: _____