Michiana Gastroenterology Inc.

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WAIVER FORM

I certify that I am eligible for health coverage under ________________________________.

I understand that the medical care I have requested **may not** be covered by my insurance health plan. I understand that I am responsible for payment of these services and I agree to pay for these charges in full, should my insurance not cover it.

The following applies to you only if box is checked:

- ❑ I am aware that this provider is out of a network with my insurance carrier and this **may** affect my benefits. I understand that I will be responsible to pay any charges not covered under my plan due to being out of network.

Please sign and return to prevent your procedure from being cancelled.

Date of Procedure: ____

Procedure(s): ____

Amount: **EGD**: $600 and up **COLONOSCOPY**: $760 and up

Physician: ____O'Dea ____Mathis ____Mark ____Gilliam ____Manbeck ____Patel

Signed: ____

Print Name: __________________________________ DOB: _____________________

Date: ____