

NEWMAN FAMILY MEDICINE

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General Waiver for Non-Covered Services

I have been notified by Newman Family Medicine that if my insurance company denies payment for laboratory, X-ray or specific procedures that have been performed, I will assume responsibility for the payment of these procedures.

DATE _____

TYPE OF SERVICE PERFORMED _____

PATIENT NAME: _____

DATE OF BIRTH: _____

PATIENT SIGNATURE _____

GUARDIAN _____