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Insurance Waiver

I understand that at this time I may not be eligible under my insurance plan. I wish to receive medical services from Dr. Waldman. If it is determined that I am not eligible for coverage, or my insurance company denies payment, I am ultimately responsible for payment in full.

Signature of patient/responsible party

Date

Laboratory Policy

We notify all our patients with all results of labs and X-rays that are ordered by either Dr. Waldman or Shawn within a **10** day period of time. If you do not hear from us within that time period, please contact us. Any tests that are **not** ordered by this office are up to the patient to contact the specialist ordering the test to obtain the results.

Please mark yes or no below, giving our office authorization to leave a message on your phone with normal test results.

YES _____ **NO** _____

Signature of patient/responsible party

Date

Medicare Patients Only

This letter is to inform you that Medicare will not cover certain routine exams. You will be financially responsible for the cost of the test or exam not covered by Medicare.

Signature of Patient

Date