GYNECOLOGY ASSOCIATES OF FREDERICKSBURG

PATRICIA L. MURRAY, MD
GEORGE E. NOWACEK, MD
DONNA L. ELDER, WHNP

Patient Name: ____
Date of Birth: ___________________

I realize that I am seeing a physician that does not participate with my insurance plan (Tricare Standard, Tricare Prime, Medicaid or _______________________).
I am willing to accept all financial responsibility for all fees incurred by any treatment provided by this physician.

This waiver will remain in effect from the date signed below until I give this office notice that I no longer am a subscriber of the above insurance.

____ __________________
Patient or Guardian Signature Date

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Patient or Guardian Printed Name