Waiver of Workers Compensation

Bellevue Family Practice

Date ____________________

Patient Name (printed) ______________________________________

Patient Date of Birth ____

I have choose to not have charges sent to Workers Compensation.
I acknowledge that if my health insurance denies the claim or if I do not have health insurance, I am responsible for all charges for today's visit. This includes the office visits, any lab, x-rays, injections/medication or any miscellaneous charges incurred.

I understand that Bellevue Family Practice will be **unable** to bill my charges to Workers Compensation at a later date.

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(Patient signature or guarantor if patient is a minor)