Rees Stephens, Inc.
BEACH PEDIATRICS
17742 Beach Boulevard, Suite 360
Huntington Beach, CA 92647
Office (714) 848-0868
Fax (714) 848-2248

WAIVER FORM

My current insurance is: _____

I wish to receive medical services from the doctors associated with Rees Stephens, Inc. / Beach Pediatrics. I understand that ultimately I am responsible for all services rendered. If it is determined that service (s) are not covered by my health plan or if there is a problem with eligibility that I will be responsible for payment of all services provided at the time they are rendered. I further understand all deductibles, co-payments and co-insurance are also due at the time services are rendered.

I also understand that I have ten (10) days in which to inform Rees Stephens, Inc. / Beach Pediatrics of any changes to my insurance billing:

- Company Name
- Group Number
- I.D. Number
- Claims filing addresses
- Primary Care Physician (HMO & POS only)

_____
Patient Name(s)

_____ _____
Responsible Party Name (Print) Responsible Party Signature

_____
Date