Patient Name: ____________________DOB:__________Acct#: 8X___________

Financial Acknowledgement Waiver

It is expected that services for your visit today____________(date) will not be covered by your insurance company _________________________ for the following reason:

- ☐ Records show we are not your assigned primary care provider with your insurance company.
- ☐ TriStar Medical Group Family Physicians has not received an authorization by your insurance company from your primary care provider.
- ☐ TriStar Medical Group Family Physicians does not participate with your insurance plan.
- ☐ TriStar Medical Group Family Physicians has not been able to verify that the insurance plan you provided is active and that you are eligible.

Signature below indicates acceptance of the balance due if the claim for services is denied for the above stated reason

____ ________________
Signature of Patient or Responsible Party Date

____ ________________
Signature of TMG Family Physicians Representative Date