**PRIMARY CARE PHYSICIAN INSURANCE WAIVER**

My insurance card does not clearly indicate the physicians of Gainesville Family Practice, P.C. as my designated primary care physician (PCP). I understand that I may be financially responsible for charges incurred as a result of this visit.

I also understand that Gainesville Family Practice, P.C. will file a claim for my visit in an attempt to collect from insurance carrier. If payment is denied, I agree to remit payment for these services. I will also be responsible for making sure that the physicians of Gainesville Family Practice, P.C. are designated as my primary care physician (PCP) prior to any subsequent visits.

Name of Patient *(please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Signature of Patient or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_