

**FAMILY PHYSICIAN'S OF SOUTHERN NEVADA**

Michael Reiner, MD Renae Goedhart, APN

**ELIGIBILITY WAIVER**

I, \_\_\_\_\_, hereby certify that I am eligible  
for

\_\_\_\_\_ as of \_\_\_\_\_  
(Name of Insurance Carrier) (Month, Day, Year)

**I understand that if I am not eligible, I will be financially responsible for all services rendered on this date and I agree to pay within 30 days of receiving a claim.**

**DATE OF BIRTH** \_\_\_\_\_

**SSN#** \_\_\_\_\_

**DATE** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**DATE** \_\_\_\_\_ **WITNESS** \_\_\_\_\_