PACIFIC FAMILY PRACTICE MEDICAL GROUP
A PROFESSIONAL CORPORATION

1 Shrader Street, Suite 578 San Francisco, CA 94117 • Phone: (415) 876-5762 • Fax: (415) 876-4538

ELIGIBILITY WAIVER

I, ________________________________, understand that I am eligible for benefits
(name as it appears on the insurance card)
under the terms of coverage from _____________________ with the Brown and
(health plan)
Toland Medical Group as of _____/_____/___________.
(effective date)
I am the subscriber/spouse/dependent under this plan.
(circle one)
I have selected ________________________________
(Primary Care Physician or PCP chosen)
to be my Primary Care Physician as of _____/_____/___________.
(date of PCP assignment)

I am aware that if any of the information provided above is inaccurate, I or the financially responsible party will be liable for all the charges for services provided to me.

____
Financially responsible party if other than patient. Indicate relationship.

____
Signature

____
Indicate relationship if signed by other than patient

______/______/____________
Date