

Date \_\_\_\_\_

Patient: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security # \_\_\_\_\_

It is my decision to waive my HMO benefits through \_\_\_\_\_. I  
will be treated by Dr. \_\_\_\_\_ under my \_\_\_\_\_ benefits.

I understand that I will be responsible all hospital/ facility and physician charges.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Witness (Print Name) \_\_\_\_\_

Witness Signature: \_\_\_\_\_

:HMOdecline