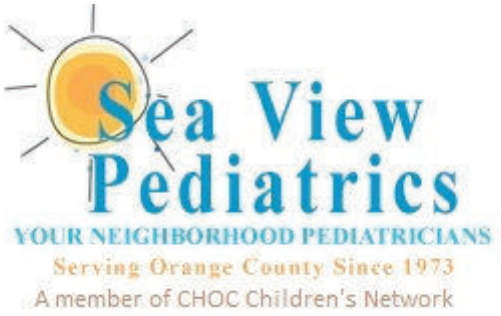


(949) 951-KIDS (5437)
Fax (949) 951-2715

# Sea View Pediatric Medical Associates, Inc.

## OFFICE POLICY & ELIGIBILITY WAIVER

I _____ understand I am eligible
(Parent Name)

For _____

(Name of Insurance)

I have chosen Sea View Pediatric Medical Associates, Inc. as the provider for my child's health care. I understand that I am responsible for all co-pays and deductibles at the time of service. It is customary for the insurance company to process the claim within 30 to 45 days of the date of filing. I understand that it is my responsibility to know what my insurance covers and I understand that if I am found to be ineligible, I am ultimately responsible for payment in full to Sea View Pediatric Medical Associates Inc., for services rendered. If the insurance company should fail to pay the claim within 90 days, whether or not covered by insurance, I understand Sea View Pediatric Medical Associates, Inc., may collect the amount of the claim from me directly.

_____ _____

Parent or Guardian (Please Print) Parent or Guardian (Signature)

_____ _____

Sea View Pediatric Witness Date