Tuscarawas County Health Department

Patient Wavier of Health Insurance Coverage

Public Health
Prevent. Promote. Protect.

I understand that I have the right to opt out of using my health insurance coverage at any time. I further understand that if I have health insurance that I choose to waive, I am no longer eligible for the sliding fee scale and will be responsible for any charges accrued during that visit.

Date of service for which I choose to waive my health insurance coverage:

____

Patient's Printed Name: ____

Signature of person financially responsible for charges accrued:

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Witness Signature: ____

Date: ____