Eligibility Waiver

Subscriber's Full Name____

Subscriber's Date of Birth ____

I (The Above Named Person) hereby certify that I am eligible for benefits effective:

Effective Date: _______

For Patient:

First Name ____

Middle Name / MI____

Last Name____

I have chosen Premier Primary Care, LLC to be my medical provider.

I understand if the above is not true, I am responsible for all charges related to services provided to me. Also, if the above is not true, I agree to pay in full for all services received within 30 days of receiving a bill from Premier Primary Care, LLC.

Date:__________ **Signature of Patient or Responsible Party:**______________________________