GROW PEDIATRICS AND ADOLESCENT MEDICINE, PLLC
NEWBORN INSURANCE WAIVER

I, _____, have not provided GROW Pediatrics & Adolescent Medicine, PLLC with my child's _____ completed insurance information. I acknowledge coverage is not effective until I have provided GROW Pediatrics & Adolescent Medicine, PLLC with the necessary insurance information for my child. I understand all balances must be paid in full within thirty (30) days. Further, I understand my signature below denotes me as financially responsible for all patient balances. This waiver states, therein, the signer accepts full responsibility for any and all unpaid charges after a period of thirty (30) days has elapsed.

Parent/Legal Guardian Signature _____ Date _____