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# MEDICAID WAIVER

I understand that Doctors West, Scarf, Conte, Bastianelli & Mazzoni are not participating with the New Jersey Medicaid program. I am waiving my right to Medicaid reimbursement and have chosen to pay Drs. West, Scharf, Conte, Bastianelli & Mazzoni for services rendered for each office visit. I am personally responsible for paying the entire cost of the services rendered to me. I understand that payment is required prior to my receiving services. If Medicaid is my secondary insurance, I will be responsible for any charges not paid for by my primary insurance carrier.

_____

Print Patient Name

_____

Patient (or parent/guardian) Signature

_____ Today's Date