THE CHILDREN'S PROGRAM
PATIENT RESPONSIBILITY WAIVER

_____
Patient Name

_____
Dental Service(s) including CDT code

_____
Diagnosis

The services outlined above are (check one):

a) _____ Not a covered procedure under The Children's Program

b) _____ Not covered because the plan maximum has been met for the eligibility year

I, _____,
(Print Parent or Guardian Name)

understand that the services listed above, for the diagnosis listed above, are not covered for payment by The Children's Program. If I choose to obtain the services listed above on this date for my dependent, I agree to be personally responsible for paying the financial charges for these services. The estimated amount that I may be responsible for is $_____, and not to exceed $_____.

_____ _____
PARENT OR GUARDIAN SIGNATURE DATE

_____ _____
WITNESS DATE