

# PIGA PRIMARY CARE ASSOCIATES

Specialists in Adult and Pediatric Medicine

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## WAIVER FOR SERVICES PROVIDED BY PIGA PRIMARY CARE ASSOCIATES

Piga Primary Care Associates provides several services to patients that may not be covered by insurance or covered fully. These services are offered as a convenience for families, but they are not required in order for a patient to receive care in the office. Insurance companies vary according to what services they cover and how much they pay for the service. Examples include EKG, spirometry, hearing testing and vision testing. Patients always have the right to choose if they would like to have the procedures performed in our office. If a patient wishes to have the service performed elsewhere, the appropriate instructions and lab request or prescription will be given if needed. Patients may elect to have the service performed in our office, but will need to pay the fee if it is not covered.

We appreciate you selecting Piga Primary Care Associates for your family's health care needs. As a provider for your company's health plan, we are committed to quality health care. Services recommended for our patients may not be a benefit of your insurance plan. Please be advised that any expense not covered by your plan, such as check-ups, immunizations, immunization administration, procedures, and laboratory tests, will be your responsibility and will be billed to you. Our routine schedule of these services follows the recommendations of the American Academy of Pediatrics and the American College of Physicians.

Well/annual exams cover preventive care. Anything that is discussed outside of preventive care, including, but not limited to, the treatment of chronic conditions may incur fees that may be applied to your co-pay, deductible or co-insurance. These fees are the responsibility of the patient.

By signing below, you agree to take full financial responsibility for the cost of the indicated medical services or procedures if not covered by your insurance.

Patient's name \_\_\_\_\_ DOB \_\_\_\_\_

Patient or Guardian's signature \_\_\_\_\_ Date \_\_\_\_\_

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