



MEDI - CAL WAIVER FORM

I _____ understand that the doctors of Fresno Children's Medical Group, Inc. are no longer accepting Medi-cal patients for pediatric services.

If I have Medi-cal or if I become eligible for Medi-cal, I want to waive my rights to use Medi-cal with all physicians of Fresno Children's Medical Group, Inc.

By signing below I realize that:

1. My doctor will be unable to bill Medi-cal for these services.
2. If I have Medi-cal, I will be responsible and obligated for these services myself.

Print Name

Signature

Date