



LEOPOLDO A. CABRERA, M.D., F.A.A.P.

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Patient Name: _____

Date: _____

Patient Acct#: _____

AFTER HOURS INSURANCE WAIVER ACKNOWLEDGEMENT

Dear Patient,

At the request of many of our patients, we are now providing after hour services. This is an added expense for this office and we must charge additional fees for this service. Some insurance companies will not pay for after hour charges, therefore, you will be responsible for these charges when they are not paid by your insurance. Please sign below that you acknowledge and accept this waiver and responsibility.

Patient/Responsible Party Signature

Date