

**South Atlantic Medical Group, Inc.**

Nissan Kahen, MD

\_\_\_\_\_, MD

**\* POINT OF SERVICE WAIVER \***

I have read and understand that the service(s) rendered by this facility are covered under my POS, and that my deductible applies when service(s) are rendered by Dr. Kahen or any South Atlantic Medical Group Physician.

**Yes, I want to receive services from this provider.**

**No, I have declined to receive services from this provider.**

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Doctor: \_\_\_\_\_